

FEBRUARY 1956

Special Issue:

Proceedings of the Seventh Mental Hospital Institute

Theme: Patient Participation and Freedom

Mental Hospitals

Topics include:

Administration; Staffing
Environment; Purchasing; Legal Aspects
The New Drugs; Child Psychiatry
Mental Deficiency; Public Relations

Also:

President's Address: Psychiatric
Units in General Hospitals
Complete Roster of Delegates





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Mental Hospitals and A.P.A.'s New Home

Mental hospitals and related institutions everywhere have an important stake in the American Psychiatric Association's new home in Washington, D. C., which will be occupied by the Central Offices in 1956. It will house the Mental Hospital Service, the Information Service, the Inspection and Rating Service of the Central Inspection Board, the Mental Hospital Architectural Study, the State Survey Office, and the other offices that carry out the official programs and policies of the Association under the administration of the Medical Director. Many public and private mental hospitals have contributed to the A.P.A. Building Fund. In several cases staff doctors have joined together to contribute in the name of their hospitals. Why not ensure that your hospital is enrolled in the Book of Contributors? Contributions should be addressed to A.P.A. Building Fund, 1785 Massachusetts Avenue N. W., Washington 6, D. C.



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THIS MONTH'S ISSUE

A well-known Broadway producer, who had five plays running currently on Broadway, was asked "What makes a play successful?" He replied "If only I knew the answer, I'd be a millionaire."

What makes a meeting successful? We wish we could capture the formula in words, but we only know that the Seventh Mental Hospital Institute was one of the most successful we ever had; not only because of the record number of delegates—422, of whom A.P.A. staff members accounted for only 13; not only because of the wide participation—131 people spoke 241 times from the floor; but because there was more discussion of the psychiatric patient as a person than any of us can previously recall.

For those who enjoy statistics, 242 of the delegates were psychiatrists; 38 nurses came, 71 business managers and administrators, and 54 from other hospital disciplines; six of the delegates were state commissioners and there was one representative of mental hygiene groups. Forty-seven states were represented, plus the District of Columbia, one Territory and 6 Canadian Provinces; the largest delegation came from Pennsylvania, which had 32 delegates to Maryland's 31. Twenty-four people came from Canada.

This year's presentation of the proceedings is a departure from the custom of previous years. The Medical Director and the Mental Hospital Service consultants felt that the discussions deserved wider distribution than has been possible by publishing a separate book.

Extra copies of this issue are available, as long as they last, at the nominal price of 50¢ each, cash required with orders of less than 6 copies. (In previous years, the book has been \$2.00 or \$2.50.)

Following last year's editorial format, however, the proceedings are presented in the form of substantive accounts of the discussions and run approximately the same length. Each participant is listed in the account of the discussions, and there is a complete geographic roster of all who attended. Historical data on the meeting will be found on Page 64.

CONTENTS, FEBRUARY 1956

Some Thoughts on Psychiatric Units in General Hospitals (President's Address, by R. Finley Gayle, Jr., M.D.)	5
Progressive Responsibility & Freedom for Patients	10
Staffing Needs for Patient Freedom	14
Environment for Greater Patient Freedom	17
Administrative Aspects of Patient Freedom	21
Forensic Psychiatry	24
Malpractice Insurance	27
The New Drugs (chlorpromazine & reserpine): Administrative Aspects	30
Child Psychiatry: Community Aspects	35
Child Psychiatry: Hospital Aspects	38
Barriers Between Nurse and Patient	42
Procurement of Supplies for the Patient	45
Administrative Interstate Reciprocity	48
Out-Patient Clinic Services for the Mentally Deficient	49
Report on the Joint Commission on Mental Illness & Health	52
Report on the A.P.A. State Surveys	53
Administrative Careers in Hospitals	55
The Role of the Hospital in Psychiatric Public Relations	58
Roster of Delegates	60

Note: The Academic Lecture, "Group Therapy in the Mental Hospital," by Jerome D. Frank, M.D., was published as a separate monograph; obtainable from A.P.A. Mental Hospital Service @ 50¢ a copy.

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(Cover design by Henry D. Chaplin)

Meet Dr. Whatsisname:

On pages 25, 27 and 52 will be found a new acquaintance. This time he is wordless, but we think his expressions indicate his feelings quite clearly. In the future, however, he will have plenty to say. Some of the most vocal individuals in psychiatry will serve as his ghost-writers. You may not always agree with him—even the Editor occasionally takes issue with his pronouncements, which are always lively and occasionally controversial.

Unfortunately he won't tell us his name. He insists on a nom-de-plume. Will you help us out by making suggestions?



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1. Hoffman, J.L.: in *Chlorpromazine and Mental Health*, Philadelphia, Lea & Febiger, 1955.

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Some Thoughts on Psychiatric Units in General Hospitals

by R. FINLEY GAYLE, JR., M. D.

President, American Psychiatric Association

SOME OF YOU who are here tonight are attending your first Mental Hospital Institute. Some of you are repeaters in the best sense of the word. And some of you are what we might call charter Institute members. You have participated in each of the six previous meetings, and have watched this enterprise grow from a small tentative experiment to its present status of proven worth.

When the Institutes were initiated in 1949, no one knew how many important contributions they would make to mental hospital care. Perhaps I should qualify this statement. Dr. Blain, who dreamed up the idea, realized at the beginning the great potentialities of the Institutes. His vision was correct. His belief in the value of these meetings has been justified.

At the start, the subjects discussed were necessarily restricted to problems of mental hospitals and particularly public ones. Steadily, year by year, the scope of the Institutes has broadened to cover wider territory. This is as it should be. The psychiatric hospital, whether public or private, does not exist in a vacuum. It does not function in isolation. Previous Institutes have shown that the psychiatric hospital is—or should be—an integral part of the community, providing some of the many inter-related facilities for the care of the mentally ill.

In line with this development of the Institutes during the relatively short period of six years, the time has come, I think, for these workshop meetings to concern themselves with psychiatric care *wherever* it is given, and to explore the inter-relation of all the mutually supportive services.

With these thoughts in mind, I am not going to speak about some specific advance in mental hospital care, or about some mental hospital problem that calls for solution. Instead, my talk deals with psychiatric services in *general* hospitals. Such services have profound and far-reaching effects. They influence patient care, medical and other professional education, the integration of psychiatry with other branches of medicine, the public's attitude about psychiatry, and the work of the mental hospitals.

Viewed in this broad perspective, the establishment of psychiatric units in general hospitals is significant for all of us who are concerned with mental illness, whatever we do and wherever we function.

Up to about two decades ago, the general hospital in *theory* provided adequate care for *all* persons in the community who required medical attention of any kind; but in practice, it consistently ignored the psychiatric patient.



Entrance to psychiatric unit,
Michael Reese Hospital, Chicago

The situation is different today. The concept of the general hospital as a community resource that serves as an *all-round* medical center is taking hold. The multi-discipline approach to patient care is gaining ever greater acceptance. There is an awareness of the emotional components in somatic illness, and an ever greater opportunity to translate this awareness into action. These developments have changed the general hospital's attitude about its functions and responsibilities. They have sharply accelerated the trend toward the inclusion of psychiatric services.

The historically minded will be interested in knowing that a department for—I quote—"the cure and treatment of lunatics" was established at the Pennsylvania Hospital in 1755. The Sisters of St. Francis Hospital in Pittsburgh, under the necessity of caring for one of their members who had become mentally ill, had their first psychiatric patient in the early 1880's. They were soon taking care of other mentally ill patients sent to them by physicians. In 1901 a psychiatric unit was opened at Albany Hospital, New York. Dr. J. M. Mosher, who established it, was among the first to recognize that the general hospital offers many diagnostic, consultant, and treatment facilities essential to the total welfare of mental patients.

The number of such services increased sporadically during the following years, but there was no pronounced trend in this direction until the past two decades. Since the mid-1930's one general hospital after another throughout the country has established a psychiatric unit. I shall not attempt to name any of them. To do so would only mean that I would omit others that are equally important. Dr. A. E. Bennett, who made a comprehensive survey of the situation and has long been interested in this field, considers the trend one of the most important in present-day medical practice.

Many Benefits Accrue

This conclusion is clearly supported by even a brief consideration of the effects of having psychiatric units in general hospitals.

We know that the possibilities of recovery in mental illness are greater if diagnosis is promptly made and early intensive treatment is available.

We know that many persons in need of early treatment do not receive it because they and their families are unwilling to go through the many and still, unfortunately, complex procedures necessary for admission to a mental hospital. When the patient can be admitted to the general hospital of his own community on a voluntary basis, he and his family are much more likely to seek help at the first indications of illness. An added factor in their willingness to do so is that the patient can more readily remain in contact with his family physician, instead of being put in unfamiliar surroundings often far from home.

Admission to a general hospital encourages community acceptance of psychiatry as a type of medical treatment; too often psychiatry is thought of as something mysterious and apart. It supports the idea that mental illness, like any other illness, can be treated and cured. It promotes public understanding of what psychiatry can do.

One of the greatest contributions of the psychiatric service is the psychiatric orientation of the hospital's personnel. All of them—administrative workers, house staff in the other services, nurses, occupational and recreational therapists, social workers, and attendants—gain a better understanding of the emotional components of illness. In a hospital dealing exclusively with what is called physical illness, there is a tendency to focus on the specific somatic pathology—the appendicitis or heart murmur, for example—and to forget the individual. Psychiatric orientation does much to counteract this tendency. It emphasizes the modern concept of treating the whole man, rather than an isolated somatic malfunctioning.

By offsetting the exclusively somatic approach to illness, psychiatry improves diagnosis and therapy in all the services. As one writer put it, we must beware of the assumption that every backache has an anatomical cause, and that every complaint the patient makes that is different from the one set down on his admission record is groundless. The psychiatrist's techniques are also enriched and improved through contact with the other hospital services.

All of us bemoan over-specialization in medicine but, to paraphrase

Mark Twain, no one does much about it. The psychiatric service in the general hospital is a potent force in breaking down interspecialty barriers or at least in lowering them. The close association of the psychiatrist and his colleagues in consultation and treatment, and their joint consideration of hospital problems tend to integrate psychiatry with all other medicine. It brings psychiatry into the general medical fold. This is where it belongs. I stress this point, for the isolation of psychiatry is still a powerful cause of the misunderstanding and lack of acceptance that so seriously handicap our work.

Even hospital personnel have been heard to use such terms as "nut department" and "psycho floor" to designate psychiatric services. And this may be taken as an indication of woeful misconceptions about the role of psychiatry in medical practice.

Professional Education Improved

As you know, it is now an accepted principle that general medical education should include training in dealing with emotional symptoms, and a general understanding of the principles of psychiatry. I hold that no physician is properly equipped to discharge his responsibilities without this training. I need not remind this audience that a large percentage of patients consulting general practitioners have disturbances complicated by neurotic or emotional conditions. The number is put at from 50 to 75 percent. The hospital that can provide a full range of teaching material covering the psychiatric as well as the purely physical aspects of illness is obviously a better teaching center for medical students and interns than one that does not admit mental patients. Moreover, it will attract interns who want experience in all-round service.

Student nurses today are also required to have some training in the field of psychiatry, even if they are not planning to go into psychiatric nursing. If the home hospital has a psychiatric department, the nurse gains experience in this field continuously throughout her period of training, instead of only during the time she spends in the affiliated mental hospital. Moreover, with the psychiatric orientation of the entire hospital personnel, as I have already noted, her

general understanding of the psychiatric approach is deepened.

The educational advantages are not, of course, limited to the medical and nursing fields. The hospital can offer advanced training for social workers, clergymen specializing in pastoral psychology, psychologists, and technicians of various kinds. It is also able to offer well-rounded in-service training.

Leaving the educational area, I want to touch briefly on the potential contribution of this form of psychiatric service in planning comprehensive psychiatric services in a community. This is a task that confronts us today and that will become more pressing in the immediate future. A psychiatric unit in a general hospital, Dr. Blain has pointed out in a recent article, provides information about the relationship between physical complaints and psychiatric needs in the hospital population. It is possible to determine how many persons in that population would benefit from psychiatric observation, how many need formal consultation, transfer to the psychiatric unit for special treatment, or continued outpatient care after discharge. On the basis of such information, it should be possible to work out indices of the psychiatric needs of larger population groups. Thus we will have some valid guidelines in determining the facilities needed for complete psychiatric service in a community of a specific size.

Misconceptions Impede Acceptance

With all these obvious advantages, one would imagine that every general hospital in the country would be establishing a psychiatric unit or trying to establish one. Such ready acceptance of the principle is impeded by many misconceptions. Some arise from lack of information, some from the all too human trait of resisting change and rationalizing that resistance.

As Dr. D. Ewen Cameron has aptly reminded us, most of the medical men who control hospital policy—superintendents, heads of clinics, and chairmen of medical boards—completed their medical training some twenty years ago. They tend to think of mental illness in terms of the clinical material they saw in the state hospitals of that day, and they do not realize that the stereotypes they have set up are no longer valid. Thus, to them,

psychiatric patients are violent, noisy, and destructive. They must be locked up. To them, mental illness is seldom amenable to treatment. There is a stigma about it, and they want none of it attached to *their* hospitals.

Let's look at the facts. Most psychiatric patients are not noisy. One or two soundproof rooms will take care of the 2 or 3 percent that are. Most of them are not violent and destructive. In any case, the few that are can be controlled by modern techniques of therapy and care. As for not wanting nervous or emotionally sick people in their hospitals, one can only reply that they are already there, even if the emotional components of their stated illness are not recognized. Moreover, somatic symptoms are often purposely emphasized in diagnosis to obtain hospital admission and to safeguard the patient's insurance benefits.

The objection that psychiatric units in general hospitals cannot be staffed is the vicious circle type of argument. Experience shows that it is possible to assemble an attending staff of part-time psychiatrists in any fair-sized city, if there is opportunity for constructive work. As matters stand, the psychiatrist is often made to feel unwelcome in the general hospital, and then the hospital complains that it cannot procure a staff. And so it goes for other members of the psychiatric team. I am convinced that a general hospital with a wide range of clinical material and good teaching and research programs will not have too much difficulty in staffing a psychiatric unit.

Finally, the complaint is sometimes made that mental patients tie up much-needed hospital beds. It should be remembered that psychiatric units in general hospitals are primarily for short-term treatment. The hospital stay is not excessively longer than the average for other types of illness; about 80 to 90 percent of admissions are discharged, usually to the outpatient service for further care. When prolonged treatment is needed, or the prognosis for remission is not good, the patient is generally transferred to a psychiatric hospital, or sent home for eventual commitment.

This brings up a point that should be emphasized. The state hospital should not be thought of as a dumping ground for patients who cannot be successfully treated in general hospitals. The latter, because of the lim-

ited number of their services and their restricted physical facilities can offer only short-term treatment. The mental hospital is not handicapped in this way. Under optimum conditions, it can offer both long-term treatment and briefer periods of intensive treatment. Ideally, both types of hospitals should be integrated into a comprehensive program for the care of the mentally ill.

Figures Show Trend

I have already spoken about the marked trend in the establishment of psychiatric services in general hospitals during the past two decades. A few figures will illustrate what has been happening. In 1939, only 37 general hospitals and 6 Veterans Administration general hospitals had psychiatric facilities. In 1940, there were 89 hospitals with such facilities, and by 1945 the number had increased to 100. In 1954 614, or 13 percent of 4,715 general hospitals were admitting patients to psychiatric services. Well over half of these 614 had separate buildings or separate departments for their psychiatric services. The remainder, while admitting psychiatric patients, had no separate facilities.

Encouraging as these figures are, they show how much still remains to be done. In terms of total bed capacity, only 4 percent of general hospital beds are available for psychiatric disorders, and this 4 percent accommodates only *one* percent of all hospitalized mental patients.

What is the goal, quantitatively speaking, for psychiatric beds in general hospitals? It is usually put at 10 percent of the total beds. This would mean 60,000 of the presently available 600,000 general hospital beds. Considering that emotional disturbances or somatic diseases with substantial emotional content are said to account for one-fourth of all admissions to general hospitals, this appears to be a very conservative minimum. I believe, however, that it would be sufficient, if the beds were properly distributed and were supported by outpatient services.

As to the size of communities that should establish psychiatric units in their general hospitals, I have said in the past that there should be such units in the general hospitals of every city of over 50,000 population. The minimum figure is sometimes put at

100,000. It seems to me to be more realistic to use the size of the hospital as the criterion, as is done in the American Psychiatric Association's *Standards for Psychiatric Hospitals and Clinics*. The section on psychiatric units in general hospitals states that any community that can support a good 150-bed or larger general hospital can usually support a psychiatric service in that hospital. Details of size, purpose and function, organization, staffing, and physical facilities are given in this section. I urge you to read them.

For our purposes this evening, it will suffice to emphasize a few points. They indicate that the physical set-up of a psychiatric unit is neither complex nor costly. They also point out that certain policies should be followed if the service is to fulfill its functions.

The unit need not and preferably should not be separate from the general hospital plant. Semi-private rooms and small wards are preferable to private rooms because they encourage group adjustment. Since almost all the patients are ambulatory, space is needed for dining, recreation, and day-time occupancy in general. Complete segregation of the sexes is not necessary. An adequate 25-bed psychiatric department can be housed in any ordinary hospital wing without prohibitively expensive remodelling. In this context, I call attention to the studies now being made by the A.P.A. Mental Hospital Service Architectural Study Project. The Project is now surveying existing psychiatric facilities in general hospitals with a view to being able to give constructive guidance about physical arrangements in the near future.

As for general policies—with few exceptions admission is on a voluntary basis by medical referral. Commitment is discouraged. Indeed, the very purpose of caring for a patient in a general hospital seems to demand that admission be voluntary.

A Summary of the Benefits

At the risk of sounding like an advertising copy writer, I want to conclude with a summary of the benefits and contributions of the type of service I have been discussing. A psychiatric service in a general hospital:

Provides prompt diagnosis and early intensive treatment, thereby increasing the possibilities of recovery.

Has a profound and immediate effect on the entire hospital staff through enriching its understanding of psychiatry.

Raises the standards of diagnosis and treatment in the other hospital services.

Betters the techniques of the psychiatrists through contact with their colleagues in the other services.

Improves training in medical, nursing, and other areas.

Broadens the scope of the hospital's research program.

Breaks down specialty barriers.

Integrates psychiatry into the general field of medicine.

Educates the community.

Promotes public acceptance of psychiatry and an understanding of its role.

Enables the hospital to fulfill its functions of all-round service to the community.

In my opinion, any general hospital worthy of the name should contain a psychiatric unit.

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1. Proctor, R. C.: Report on Frenquel in acute and chronic psychotic states. Presented before the Bowman Gray Medical Society, Winston-Salem, North Carolina, May 16, 1955.
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Progressive Responsibility and Freedom For Patients

Chairman: Charles K. Bush, M.D., Washington, D. C.

Discussion Leader: Harvey J. Tompkins, M.D., New York, N. Y.

Presentation:

Outstanding during the past ten years of psychiatric activity have been the spectacular growth of the private practice of psychiatry and the increased knowledge of psychiatric principles. This has led to improved therapeutic techniques and the increase in quality and scope of training and research opportunities. So dramatic are these developments that it is easy to overlook the amount of constructive attention which has been given specifically to the intramural care of the mentally ill and retarded.

Many were engaging in construction programs immediately after World War II and this brought into sharp focus the need for better understanding by architects of the functional needs to be served by hospital buildings. There was discontent with precedent, with things as they were, not only in architecture, but also in staffing patterns, organization and administration. Gradually our emphasis was shifted somewhat from the attitudes of the community towards psychiatry and particularly towards psychiatric hospitals, and redirected towards attitudes within the hospitals themselves.

Reports in the professional literature began to question current concepts of intramural care and treatment and indicated new avenues for exploration. The hospital as a social unit became more and more significant. Many of us, overcoming certain resistances, invited social scientists to examine, criticize and suggest. Their findings were illuminating and at times disturbing.

At the same time the increasing number of disciplines represented in the hospitals not only provided expanding opportunities for diversification of treatment, but brought about organizational problems particularly

in staff relationships and their effect on patients. Studies were made of the interaction of environment on patients and staff; of patient interactions; and of the interworkings of staff and patients. With all this came a demand to examine philosophies, policies and procedures with a view to promoting greater patient freedom and greater patient participation in treatment. Many findings and recommendations have become lost to us in this country—but apparently not in Europe. Mr. Guttersen, in reporting on his world tour under the auspices of the A.P.A. Architectural Study Project, speaks of more patient freedom and responsibility abroad as it is reflected in architectural design. He emphasizes the need for further study of these trends and their application to the hospitals in this country.

Dr. D. Ewen Cameron developed his concept of the open hospital and has brought it into being in Canada. The Expert Committee of the World Health Organization, of which your Medical Director is a member, takes issue with our tendency to build mental hospitals approximating the general hospital, and questions the advisability of our extensive development of psychiatric services in general hospitals.

This is a fluid and stimulating situation. All of us have been a part of and many have taken active part in this critical examination of hospital care. We have had time to reach certain tentative conclusions.

What are we talking about when we indicate that there is need for greater patient freedom or greater patient participation in treatment? Are we locking up too many people? What is meant by more patient responsibility? In what ways does it benefit the patient? What are its implications, organizationally, administratively and architecturally? Above all, what are

its implications therapeutically? How do we apply these new concepts, if we agree with them, to the large mental hospital, the private hospital and the psychiatric service in the general hospital?

Discussion:

Participants: Daniel Blain, M.D., D. C.; Wilfred Bloomberg, M.D., Mass.; I. W. L. Clancey, M.D., Sask., Canada; James O. Cromwell, M.D., Idaho; George W. Davis, M.D., La.; John J. Donnelly, M.D., Conn.; Addison M. Duval, M.D., D. C.; W. Everett Glass, M.D., Mass.; Granville L. Jones, M.D., Va.; Simon Kwalwasser, M.D., N. Y.; Winfred Overholser, M.D., D. C.; Lucy D. Ozarin, M.D., D. C.; Walter Rapaport, M.D., Calif.; Mrs. Anna Scruggs, Okla.; Mrs. R. R. Tamargo, N. Y.; Mesrop A. Tarumian, M.D., Del.; William W. Thompson, M.D., Ore.; Rodolph H. Turcotte, M.D., Mass.; Isaac N. Wolfson, M.D., N. Y.

One of the reasons for this discussion of additional freedom for patients—open wards and additional responsibility—implying as it does, greater patient participation in treatment, is the many restrictions which have been in force for so many years in most large mental hospitals, irrespective of the needs of the individual patients. But are we today, in considering greater patient freedom, replying to cultural pressures, or are we really considering the needs of the individual patient?

Dr. Bloomberg said the mental hospital has two distinct functions entrusted to it by the community. The first of these is the protection of the community itself. This cannot be ignored. It is our responsibility to protect the family from the behavior of the patient who has made considerable trouble and difficulty for them, and perhaps gravely discommoded the

lives of his wife, his children and his associates. It is also our responsibility to guard the public against the rare individual who does, on occasion, become violent, antisocial or even homicidal. This we can do, and still treat the patient adequately. But we dare not forget this part of our mission.

The second aspect of our responsibility, he went on to say, is of course the treatment of the patient himself, to meet his individual needs, to allow him the protection which he implicitly requests, to grade his dependency relationship as he progresses in treatment and to give him the necessary opportunities for growth. And here we must ask ourselves the question—is freedom good for patients, for all patients, for this particular patient? Is it good for a patient to come into a hospital where there is no restraint, where there are no locked doors, where there are no limits set upon his behavior?

On theoretical and philosophical grounds, continued Dr. Bloomberg, we know today that in treating patients, just as in raising adolescents, it is important to have somebody set limits so that they know they are being protected from their own impulses. We are today in the stage of psychiatry where we accept the idea that no psychotic patient is so completely out of contact with reality that he hasn't some part of him left which recognizes that he is ill. This portion of the ego often needs the support and assistance of somebody who will come along and

lock the door and say in effect "This far you may go, and no farther."

The question, therefore, of running a completely open hospital is one that will have very limited application in most places. The patient freedom which we shall discuss may be for the most part confined to the hospital itself.

Individual Needs Key to Freedom

Dr. Donnelly said that it is quite clear to most of us that there have been in the past all too many restrictions upon the freedom of patients within the hospital, not because of the needs of the patients themselves, but because of the organization of the institution. This organization is limited by a number of factors, including budget, number of personnel available, and so on. Thus, because some patients must be restricted for their own good, others have been restricted who should not have been. The real problem, then, may be to take the individual hospital and weed out those patients who need security in varying degrees and those who do not. The particular situation and the particular patient must be considered. We cannot solve the problem by arbitrarily deciding that every hospital should be opened, or that even most wards in every hospital should be opened. We must make a much closer evaluation of the needs of each individual patient.

Now this may seem a dream, with our present budget and personnel lim-

itations. Nevertheless, even today with the help of the nurses, aides and therapists, the medical personnel can get real information about individual patients. Reorganization of staff efforts can help to arrange for greater freedom for patients who are able to make use of it.

It was the consensus of the group that if we are to allow patients within the hospital greater freedom than they have been permitted in the past, we must use our common sense in forming this judgment. Certainly if a patient is to be returned to his home and expected to readjust to community living, he needs within the hospital a living experience as close as possible to that which he will find when he goes out. It would have been absurd, however, to have put him in the hospital in the first place if he could have handled *all* the freedoms to which he was entitled in the community—there would have been no need for hospitalization. Yet it is as foolish for us to lock up a patient for one year, or two years or ten years, and then expect him to get along outside immediately upon leaving such an environment, as it would be for some of our friends in other specialties such as orthopedics, internal medicine or surgery to keep a patient in bed for a year and then expect him to get up without dizziness, weakness or even some apparent neurotic difficulties.

Because of this growing concept of patient freedom there may be risk of granting too-early discharges. The



Additional privileges may increase the administrator's problems, but patients who can assume some responsibility for their own actions need enough freedom to develop within their capacity. A privilege period before discharge may assist in social readjustment. Here a doctor discusses patients' problems of readjustment.

community is not yet able to provide the necessary facilities for support and after-care of convalescent mental patients, and without this needed support and help they are likely to return to the hospital. Although the high readmission rate which so alarms some people may result from too-early discharges, it may also show that the hospital administrator is taking advantage of social forces in the community to help in the rehabilitation program. It might even be argued that there are certain advantages to the patient himself in being in and out several times, rather than spending the whole period of his illness in the hospital.

Grading of Privileges Tried

We must question whether the open ward within the hospital is desirable for all patients if we are to achieve our therapeutic aims. Are there unfavorable incidents which should be considered before we attempt an arbitrary answer? If we decide that a hospital cannot consist of all open wards, how can we go about deciding who is and who is not ready for a degree of freedom? Can one, for instance, divide patients, as do some hospitals, into acute and chronic, and handle these two groups differently? Obviously the road back to the community is quite different for the patient who has been in hospital for many years, and is only now beginning to assume a little responsibility for his own actions, than for the acutely ill patient who has had a quick remission and is on his way home after only a month or so.

Some hospitals grade increased privileges, so that these privileges become part of a planned therapeutic program; such a plan does not imply by oversimplification that if a person gets out of a locked ward he gets better, but that if he is given freedom and misuses it, this experience can be used to give him additional insight into why he is sick, why he needs to be locked up and what are some of his problems in behavior and in acting out. Patient self-government has a function here. The patients are not permitted to decide who shall or who shall not go out on a pass; but they do have a much greater share in the operation of the hospital or even in the ward on which they are still locked up. If the patient is treated like a



This patient government group is discussing the proposed opening of the ward; if they feel there are problems to be worked out, the ward remains closed until they feel ready for additional freedom. Such groups can help and support privileged patients.

child, he will act like one; but if he is given adult responsibility it is surprising how often he will respond by accepting it. Patient-government can frequently help with those who are given grounds privileges, and who, while able to accept some responsibility for themselves, still need support and help from other patients as well as from the staff.

Some Patients Need Restraint

Perhaps this is similar in kind to the progressive freedom and responsibility allowed to children. We give children freedom to grow, to develop their capacities, but we set limits in order to protect the child from going too far and injuring himself. As the child, or as the psychotic patient gets better able to handle responsibility, the area of freedom is extended. There will always be limits within which the patient in the hospital can be permitted freedom and it is fascinating

to see how the patients themselves will set up what might be called a "psychological wall," which is much stronger, even, than a ten-foot stone wall. The stone wall is in some ways less of a challenge to scale!

Dr. Turcotte said that some patients insist on being locked up, insist on being put in sheet restraint because they feel a tremendous need for this. If we refuse to lock them up, we are depriving them of what they need, thus compelling them to suicide, or to acting out to such a degree that we are forced ultimately to restrain them, physically or otherwise. These are patients who need restraints—for whom freedom is not desirable.

So if we are to give more freedom to more patients, and still meet our dual responsibility of protecting the community and of providing a sufficient area of freedom for the growth and recovery of the patient, we need what might be called more "energy."

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This energy can be gained, of course, only from human resources, in other words, from the staff in mental hospitals. More staff means more money, yet if you have a hospital where a large number of patients are given the freedom of the grounds, but do not have enough personnel to give them the necessary supervision, unfortunate incidents will occur. Each patient should be given freedom when he needs it, and the protection of the locked ward when he needs that. Without such finely attuned judgment, we will have patients on locked wards who should be free and vice versa. There is no point in increasing a patient's freedom unless such freedom will be therapeutic to him personally.

Moreover, because a patient is able to have freedom of the grounds, or because such freedom is beneficial to him, this does not mean that he is necessarily well enough to go home. The pressures and difficulties of the home, the allergic and noxious atmosphere from which he has been freed by his hospitalization might well cause an exacerbation and send him back to the hospital again. The whole question of patient freedom is a highly individualized one.

That some degree of freedom, probably far greater than has been customary, is needed to enable patients to take part more actively in their own therapy, is indubitable. That the amount of such freedom must be compatible with the duty of community protection leads to the question of community education. Certainly as much freedom should be allowed as community feelings permit. An administrator should be cautious but not overcautious. It is a matter of community education as well as of psychiatric techniques. After all, fifty million people in the community might be said to be abnormally inclined, with obsessions and phobias which interfere with the normal flow of living. And when a patient has control of delusions and is not belligerently inclined, he is probably capable of adjusting himself to normal situations and might be considered as a fit subject for discharge.

Dr. Tarumianz said that smaller institutions might be a part of the answer to the question of discharging the patient back into a community

whose attitude will permit it to accept and support him during his convalescent period. It is ridiculous to gather mentally ill people under one roof, creating an isolated empire of ten or fifteen thousand people whom the community considers "different" and "foreign." Smaller institutions and branches of institutions of not more than two or three hundred people, to which the community could come and from which patients could go fairly freely, would help adjust the community to the needs of the discharged patient. In such a setting people would be more likely to accept our discharged patients as fit to mingle with the rest of the group.

Being able to "get along with people" frequently bears no relationship to whether or not a patient has been cured, said Dr. Clancey. Indeed, some who go home and get along quite well are in fact still very sick people. But the maximum of freedom, responsibility and association with others during the hospital period as is compatible with the therapeutic needs will help with the post-hospital period.

Freedom should be graduated and given with great caution because of our professional responsibility for the patient's therapy and our social responsibility for the community's protection. Nor must we forget that the attitudes of the community strongly affect the way we treat our patients in the hospital. This frequently impedes our application of what we know at the present time. We are strongly influenced by the way the community feels in what we do and do not do for our patients. Certain restrictions have come into being which wouldn't exist if people understood better what we know is good for the hospital patient. Thus because of these current inabilities to treat the patient as we know he should be treated, we do at times accentuate his illness. If such accentuation leads to even one patient suicide, then it is significant.

Meeting Patient & Community Needs

Underlying all our discussion is the question of meeting both the needs of the patient and the needs of the community. This is a difficult task. We recognize it as such because we have progressed in psychiatry, in our understanding of ourselves, of the community and of our patients.

Dr. Duval summed up the discussion by saying that here, as in most of life's problems, there is a middle road. Those who have the responsibility of caring for patients must look at the thing from the viewpoint of their local and specific problems and come to their own studied conclusions as to what is best in their particular situation.

The decisions concerning patient freedom, for instance, in a hospital in a rural community, may be quite different from decisions which would be made in St. Elizabeths Hospital, Washington, where Congress is practically on the doorstep. Some of the unfortunate things, moreover, which do occur when a patient has been given freedom, are calculated risks, and may well have been based on good psychiatric judgment.

This is an exciting period in hospital history, he continued. Changing social attitudes, group therapy programs, activity programs, socializing influences being brought into the hospitals, the "use of the self in therapy," the relationships of ward employees to individual patients, how much freedom we should or should not give patients, the intergroup relationships, all tied in with the impact of the new drugs has brought us into one of the great research eras in psychiatry.

We must continue to exchange information and experiences. We must put this growing body of experience to work in our hospitals. We see many things happening—more patients leaving the hospital earlier, more patients having privileges and responsibilities, more patients taking part in activities—yet we don't know the answers to all these things. What is it here that we must look at and understand to see what are the influences for positive therapy and what are the influences against it?

It may not be possible to unlock all our wards—to have all our hospitals open. We should feel no compulsion to do so against our better judgment. But we should meld all these experiences with greater freedom into the best possible approach for our individual hospital and our individual patients. We must never forget that psychiatry is in essence an individual approach to therapy, even though we have so many thousands of patients.

Staffing Needs for Patient Freedom

Chairman: Charles K. Bush, M.D., Washington, D. C.

Discussion Leader: George E. Reed, M.D., Montreal, Canada

Presentation:

In the old days, for those of us who can remember far enough back, it was pretty simple for a doctor to write an order in the order book, and the nurse to carry it out. When all wards, single rooms and gates are locked up, administrative routines are simple to establish and can be strictly maintained.

But as you increase freedom, these things get a bit vague. The role of the patient changes, and the role of all the staff changes, particularly the nursing staff. Both patients and staff have to assume new responsibilities. People have to be prepared to handle responsibility by training and with proper supervision and support. This holds true for both patients and staff! We may need to find new techniques to meet our needs.

What resistances are you going to meet from your staff and at what levels? Some of the resistances are likely to be among the best clinicians.

Let us suppose for a minute that we are faced with the fact, whether we agree with it or not, that we have to run an open hospital within a given time. I know it is generally agreed that such a program is best started gradually. But let us not say what we think about the idea—for the discussion let's simply say we have to do it. What are we going to do to help our staff operate and to overcome the resistances that will be met even in the situation where we have no choice?

Discussion:

Participants: Freeman H. Adams, M.D., Calif.; Crawford N. Baganz, M.D., N. J.; Nathan Beckenstein, M.D., N. Y.; Wilfred Bloomberg, M.D., Mass.; Mary Corcoran, R.N., Pa.; James O. Cromwell, M.D., Idaho; Hayden H. Donahue, M.D., Okla.; Charles D. Feuss, M.D., Ky.; John G. Freeman, M.D., N. Dak.; Mr. John V. Gorton, N. Y.; Walter M. Gysin, M.D.,

Ky.; Simon Kwalwasser, M.D., N. Y.; Eleanor A. Loija, R.N., Ky.; Elsie C. Ogilvie, R.N., Wash., D. C.; Robert R. Prosser, M.D., New Brunswick, Canada; Anselm Schurgast, M.D., Conn.; Mesrop A. Tarumian, M.D., Del.; Rodolph H. Turcotte, M.D., Mass.; Robert E. Wyers, M.D., Calif.

When you open a hospital, or open a ward in a hospital, you are in effect giving a p.r.n. order to nurses, aides and staff members of whatever disciplines are involved to give what might be termed "psychological medication." The responsibility of these individuals is greatly increased. How well this additional responsibility will be met depends on what sort of staff you have, how well this staff have been oriented, what goals have been expressed and what the attitude is of the administrator himself.

Every hospital administrator worthy of the name, said Dr. Baganz, is an individual dedicated to the purpose of discharging as many patients as possible from the hospital, and giving as many privileges as possible to the patients who will remain.

The whole purpose of opening wards, therefore, is to increase the therapeutic atmosphere of the hospital. If this increased freedom, however, is to be therapeutic and not merely humanitarian, we must remember that while anyone can be a jailer or a guard, it takes training and understanding to be a therapist.

The problem is not entirely how much staff there should be, but how we should use the staff we do have, said Dr. Schurgast. It is a matter of deploying people to get the most out of their services.

There are men who are operating completely open hospitals with no rooms closed at all. The ward doors are closed at night in the same way as we close the doors in our private homes. This may sound impractical, but it is being done.

If we consider how many patients

among the thousands in residence actually need to be locked up, we get a different perspective. How many closed wards do we need because we have perhaps half a dozen or a dozen really dangerous patients? Perhaps we need better patient segregation on an institutional level rather than on a ward level.

Where such programs are going on, the patients themselves do the work of the hospital with the staff, thus immediately relieving the nurses and occupational therapists. The volunteers take part too. And of course the whole scheme is based on occupations of all kinds. Not only nurses, but all the employees work on the team with the patients. Sometimes it is difficult to tell who are patients and who are staff. It is an established fact that in some hospitals with this open door operation, the number of nursing staff has been reduced.

How Can Staff Be Trained?

Yet the question is not so much how many patients in any one hospital have freedom. The question is, if those programs are working, how is the staff able to permit that degree of freedom among patients and how can we help our staff to do this?

Staff will enter fully into the whole program of trying to increase patient freedom, ground privileges, and so on, only so long as they are listened to and consulted. There must be free communication upward and downward, between the ward physician who has the final decision to make, and the people who live with the patient hour after hour and day after day, and therefore know a great deal about him.

If staff members are "instructed" to help difficult patients accept more freedom, said Dr. Kwalwasser, it never works out. Consciously or unconsciously they manage to provoke the patient.

Suppose an attendant, well ac-

quainted with a patient, does not approve of this individual having parole, ground privileges or what not? asked Dr. Turcotte. The doctor is in charge, after all, and overrules this opinion. The attendant thereupon not only washes his hands of the whole thing, but in effect, unconsciously incites the patient to get into trouble. Then he goes to the doctor and says "See?"

Dr. Baganz said that we could not therefore institute such a program in too much of a hurry. Should we first establish minimum requirements that a patient must meet before he can have privileges? he asked. Should he be required, for instance, to keep his clothes on? Be in good enough contact to find his own way back to the ward? Get back to the ward reasonably close to his meal hour? Should he be required to be able to take care of personal hygiene—bowl and bladder functions included—in a reasonably acceptable manner? Should he have enough insight so that he will continue his therapeutic program unsupervised, where he previously had supervision? Many patients, when granted privileges, automatically stop treatment programs as no longer necessary. While this is a little off the subject of staffing, it is one of the problems of the staff.

Giving Staff Responsibilities

If we think some patient screening is required, who should do this screening? There are all too few ward physicians, psychologists and social workers. But more important than which professional discipline does the screening is that it is done by someone well acquainted with the patient, his habits and behavior. If we accept the observations of nurses and aides, we will not only have fewer incidents but a lessening of antagonism. Elopements, of course, will increase, but as long as the patient is not homicidal or suicidal, there is not much harm in taking a calculated risk. Nor must we punish other patients by withholding freedom because some have run away.

With the lessening of antagonism, relations between doctors, nurses and other personnel, so vital in terms of what happens to the patients, will improve. Staff tension is relieved if anybody, from the resident through the nurse, through the aide, may in

an emergency, restrict a patient if he feels it necessary.

This gives personnel the feeling that they can stop things from going too far, from getting out of hand. They feel that if they do withdraw privileges for the good of the patient, they will have the backing of the administration. It gives everyone a sense of responsibility and makes everyone aware of the need to protect the community, protect the patient and at the same time give him all the privileges he can handle.

On the other hand, some residents may propose that policies encouraging patient freedom be carried too far. If, however, they are given the responsibility personally, which is part of the education of personnel, they will not be found so willing to accept full responsibility for what happens. If a patient gets too noisy and troublesome, the resident in turn may take the matter up with the nurse and make it her problem too. Then a remarkable thing happens. The nurse gets interested and it becomes a personal matter to her, to the resident and to others, whether this patient's freedom is to be restricted or not! It is remarkable how many patients are improved by this increased interest.

The administrator may well feel that making the rules and regulations governing patient freedom and such matters, is his own peculiar personal responsibility. On the other hand, good staff is educated by sharing responsibility. Dr. Cromwell made this point and described how he had built a stronger and more effective set-up by allowing more and more members of the medical staff to frame rules and regulations. Thus each doctor is responsible for the administrative decisions made on his own patients; at brief, regular staff conferences, all members must either indicate support, or give reasons why they would be unhappy about supporting such decisions.

It is important for the nursing service in particular to understand clearly what the administration is trying to do when it inaugurates open ward policies. The responsibility of the ward nurse and all the nursing personnel is to provide the therapeutic atmosphere patients need. The old concept of simply watching patients is changing. An educational pattern

of "doing with" instead of "doing for" the patients is developing. The interaction of various disciplines in caring for the patient is of great importance in this patient-freedom program.

It is a moot question whether more or less staff are required with more open wards. If the nursing staff required on an open ward is decreased, suggested Dr. Donahue, there may be need for increasing the numbers of other staff—the higher priced physicians, psychologists and social workers. Treatment must continue even if nursing supervision is decreased. Apart from the therapeutic aspects, it is hard to say whether the economics are sound or not. Yet if we are giving greater privileges simply to save on money and personnel, we are not functioning on a very high level. Indeed, to speak of increasing patient freedom and saving money in the same breath is to speak of two quite different things.

Some think we need more and not less personnel, to handle open ward and privilege situations. Yet simply to increase the staff may not necessarily lead to better nursing care. Staff may find one another more interesting than the patients; group discussions may lead to patient neglect. There is obviously need for better-trained personnel, for more mature people, possibly at higher salaries.

It may cost more to have a good therapeutic situation with open wards, if more and better staff are required. However, if by this means we get the patients home earlier, we are saving money.

Convalescent at Critical Stage and Needs Continued Supervision

The crucial matter, however, is to have adequate staff—adequate in quantity and adequate in quality. The patient who is given privileges is similar to the patient convalescing from a physical illness, said Miss Ogilvie. He is in a critical stage of his illness and we must observe the degree of recovery attained. We cannot open all the wards and let the patients sit out under the trees unsupervised and unobserved.

Some hope that opening wards may decrease the need for personnel since the basic philosophy is to educate the patients to accept additional responsibility. Here the patient-government

groups certainly have a function. The patient's own ability to handle his freedom can be enhanced by this group. The patient group can see that patients appear for treatments, meals and bed at the proper times. The ability of the patient to work and carry on mutual activity may determine his acceptability on an open ward and the patient group can support him in this. The patient group can bring problems to the supervisor, the director of nursing and the psychiatrist, and such decisions as are made can be brought back to the group for discussion. This kind of patient-government means to each patient that he is important and valuable and useful. Miss Loiija said that at Eastern State Hospital every patient who has served as President of this group has been discharged.

Another way of deploying staff is by allowing patients to go off closed wards as their behavior improves, so that there are no wards in the hospital in which a patient cannot be considered for grounds privileges, said Dr. Adams. This allows heavy staffing on more disturbed units and also permits the patient to test his stability outside the ward while he is still under therapy. It gives personnel a little more support and at the same time gives incentive to see patients improve and receive privileges.

Community Attitudes Have Bearing

Dr. Baganz said that community attitudes strongly affect the establishment of privilege programs. Although we have progressed a long way from the time when hospitals were started primarily to remove objectionable people from the community, the administrator still takes a shellacking if Patient Joe Doakes commits vandalism or theft while out on parole or after discharge. Inevitably, after a few such experiences, the administrator develops a more conservative attitude toward this problem than the physician who has only a physician-patient relationship to deal with. At an A.M.A. meeting not so long ago, some highly respected physicians expressed serious doubts that any mental patient ever really got well! And if you are in a tax-supported hospital, the community which supports you will tell you in effect who may be discharged and who may be put on privileges.

Yet to some extent the attitude of the community depends upon the attitude of your personnel. You must first change the staff attitudes so that they will understand this new approach. If you can then prepare your personnel and your community to work together—as in the case of elopements, paroles and discharges—you will eliminate this terrible community hostility.

The volunteer services, too, have considerable effect upon community feelings. Since we admit that community attitudes govern many of our activities in hospitals, we must also realize that the volunteer is our best community contact. The community will listen to her far more readily than they will listen to the superintendent of the hospital, who they suspect is probably biased anyway.

An example of changed attitudes on

the part of patients, personnel and community may be found in the tuberculosis sanatoriums, said Dr. Reed. Years ago they were started as isolation hospitals. The public was afraid of tuberculosis. The medical profession knew that it was infectious and dangerous—a sort of chronic plague. Yet for 20 or 30 years now these sanatoriums have looked upon themselves—and the community has begun to accept them—as places to educate the patients in how not to make themselves worse and how not to spread infection. They have taught their patients how to live at home without infecting their family and friends.

Shouldn't we start looking at the mental hospitals, not as places where we shut people up in isolation, but as places where we teach the patients how to live?



A new pattern of employees "doing with" a patient instead of "doing for him" is developing. The interaction of all disciplines in working with the patient is vital in any program which seeks to increase his freedom and responsibility.

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Environment for Greater Patient Freedom

Chairman: Harrison S. Evans, M.D., Ohio

Discussion Leader: Paul Haun, M.D., Penna.

Presentation:

To make our discussion a little more concrete and precise, I suggest the alternative title "What contribution can the physical structure of the hospital make to patient care?"

There are some who speak disparagingly of the accent on the construction of physical facilities for the care of the mentally ill. Such complaints forcibly imply that an enlightened fiscal policy would mean the channeling of financial resources away from capital outlays and into salaries.

An objective appraisal of this viewpoint is indicated. Nobody seriously holds that a conventional automobile operates at peak efficiency without gasoline and a driver. Neither is it widely believed that the finest new hospital building automatically admits, diagnoses, treats, houses and feeds mentally ill patients left on its doorstep.

We seem to agree, however, that today's carefully engineered automobile is much to be preferred to the oxcart, the sledge and the Indian travois. The complex activities of modern diagnosis and therapy can, of course, be carried out in a wide variety of settings, but do we want to claim that the nature of the physical environment is irrelevant? Are we content with our firetraps, our cracked walls, our festering soil pipes and our barred windows so long as we are assured of the human skill necessary for the job in hand?

Let us assume for the sake of this discussion that our mission as hospital psychiatrists is best carried out (a) when there are adequate numbers of trained personnel working together

toward common professional goals; (b) where there is accent on training and research; and (c) where the physical plant is safe, efficient, flexible and attractive. Let us confine our attention to the last of these requirements, and deal first with those factors bearing directly on patient welfare. Secondly, let us consider the relationship between physical structure and the convenience and comfort of the personnel.

Employees Are People, Too

We are peculiarly self-conscious in this last area. We do not hesitate to provide our secretaries with posture chairs and electric typewriters because of the obvious connection between their personal comfort and their job efficiency. Yet we are so fearful of pampering the hospital employee whose personal comfort is also related to his job efficiency that we insist he must work, relax, live and play in the most Spartan surroundings.

Are we really concerned with patient care when we quarter our physicians and their families in \$3,700 cinder block houses? Are we thinking clearly about recovery rates among our patients when we ask our attendants to change their uniforms in a noisome corner of some mildewed basement? Do we attract qualified professional nurses and improve the calibre of their work by locating linen, supply and medicine closets according to the whim of an economy-minded individual rather than for the maximum convenience of a footsore nurse winding up her day's tour of duty? Are we contributing to staff morale by economically designing electric circuits so that only 40 watt

bulbs can be used in a new personnel dormitory?

We are all beginning to give much more than lip service to the belief that patients are, in fact, people. May not an inevitable corollary of this belief be the firm conviction that members of our hospital staff are also people? The compelling reason behind such a viewpoint has nothing to do with social welfare, individual rights or the arguments of the trade unionists. It does have an essential, compelling and all too frequently ignored relationship to patient care.

Since few of us selected the site on which our hospital was built or were privileged to advise the architect as to its design, we must for the most part deal with what we have. From time to time we may be able to guide a new building program which either expands our bed capacity or augments our therapeutic resources. The initial impression of the hospital upon the patient, the new staff member and the visitor is made up of many factors, some of which are under our control. What can we do with directional signs, grounds, fences, roads, sidewalks, guard stations and the façades of our existing buildings to convey the impression we wish upon the patient, the new staff member and the visitor?

Discussion:

Participants: Richard H. Anderson, M.D., Utah; C. N. Baganz, M.D., N. J.; Nathan Beckenstein, M.D., N. Y.; Wilfred Bloomberg, M.D., Mass.; Joseph B. Bounds, M.D., Mo.; Mr. Elias Cohen, Ind.; Mr. Harry N. Dorsey, Pa.; Daniel Haffron, M.D., Ill.; Francis W. Kelly, M.D., N. Y.; Daniel Lieberman, M.D., Calif.; Leo

P. O'Donnell, M.D., N. Y.; B. F. Peterson, M.D., Tenn.; Walter Rapaport, M.D., Calif.; Elizabeth P. Ridgway, O.T.R., Pa.; Joseph G. Sutton, M.D., N. J.; Mesrop A. Tarumianz, M.D., Del.; Isaac N. Wolfson, M.D., N.Y.

(Ed. Note: Dr. Haun's presentation raised so many questions that we have taken the editorial liberty of transferring some of his comments into the discussion section as a means of introducing new aspects.)

No matter how acceptable the construction of any hospital, we have to have trained and adequate personnel to do what we are able to do for patients, said Dr. Bounds. However, in the so-called Haun-type hospital,

of which the Veterans Administration built six, there is no question but that the morale of the personnel who work in them has been infinitely improved. All those hours of administrative figuring and hassling and fussing for space have been eliminated, and those hitherto wasted hours are going toward patient care. Basically, a well-designed modern hospital creates and enforces more interpersonal relationships—that is, it allows more staff time per patient.

In all our discussions up till now it has been implicit that these staff-patient relationships are vital in operating a treatment program which fosters patient participation and patient freedom.

In a new Receiving and Treatment unit at Mendocino State Hospital, Dr. Lieberman said, he experimented by concentrating a large proportion of the relatively few personnel available in this unit, even at the expense of the other patients in the hospital. Yet during the past six months, the discharge rate throughout the hospital has been higher than the admissions rate. It is believed that the environment created by this new facility and the transfer of a group of maximum security patients to another hospital have caused personnel to view patient treatment in a different light, whereas formerly they had been used to the "maximum security" attitude. This is an interesting example of the improvement in personnel attitudes and consequently in patient care by a better facility.

Good Environment Improves Behavior

Whereas it is said that to spend ten or twelve thousand dollars per bed for a new building and at the same time not to allow more than two or three or four dollars per day for patient care is a paradoxical attitude on the part of our citizens, we must face the fact that the behavior of patients improves under good surroundings. If you create a pig sty you must expect people to behave like pigs. If you create a pleasant, home-like environment they react to it. A good many years ago, said Dr. Bloomberg, Dr. Harry Solomon, in line with the notion of getting lamps, drapes and other pleasant things into hospitals, built a new ward for disturbed patients in a small hospital. He put in a great big picture window that looked out on a beautiful valley. Everybody said "You're crazy. It won't last a week."

He said, "Patients don't destroy things that give them pleasure." In two years of operation the closest approach to a break in the glass was caused by a patient who got on a chair, took off his shoe, and hammered the ventilator above the glass, but very carefully avoided hitting the glass.

Most superintendents, however, are faced with the need of adapting existing hospitals in order to improve environment, since they have little or no opportunity of helping to plan a new one. There is general belief



A patient can regress on grounds privileges, or make a "good hospital adjustment" yet fail in the community. Freedom, to be therapeutic, must be freedom to take part in meaningful activities.

that the first impressions created by the institution on new staff members, new patients and their relatives is of great importance. The grounds should be well kept, the buildings neat and clean. There should be curtains in the wards and day rooms, in the attendants' quarters; rugs on the floors; the rooms should be painted in various colors—some of them according to the patients' own choice (which might differ radically from that of the superintendent himself!)

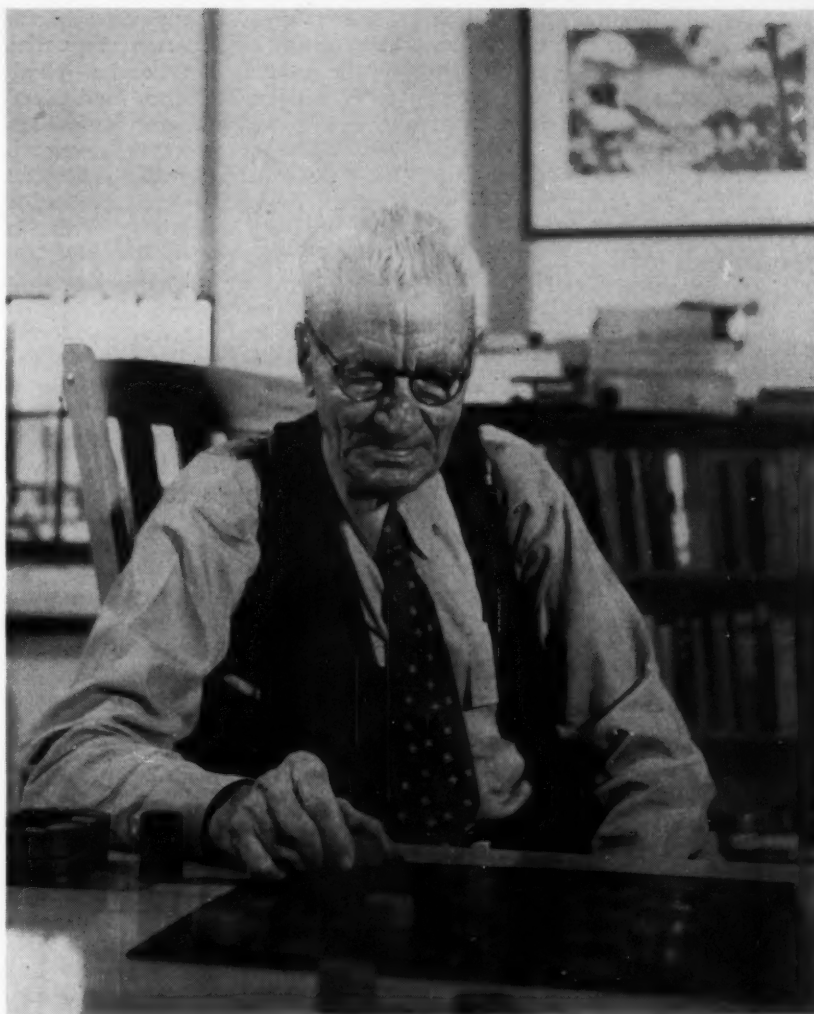
Dr. Beckenstein said that at Brooklyn State Hospital a volunteer organization fitted up a ward with chrome and plastic furniture in different colors and donated television sets and other things. Small tables were put along the corridors of another ancient hospital, with table lamps on them. In two and a half years not one of the lamps has been broken. Narrow rooms have been "widened" by painting murals of hills and brooks and Chinese pagodas on the walls. (Water paints can be washed off when the patients tire of the existing murals.) An enterprising aide in another hospital helped patients put up an artificial fireplace with bookshelves alongside and an aquarium on each bookshelf. Parakeets and canaries were introduced and cared for as part of a patient project.

Some of us have become so used to giving patients knives, forks and spoons instead of a spoon only, and china instead of aluminum trays, that we forget that this is not yet universal; and we forget, too, how very important these things are to the morale of the patients.

Involve Non-medical Staff

As well as patient participation in such improvements, it was suggested by Mr. Cohen, one good method is to recruit competent, well-trained non-medical administrators and delegate to these people the responsibility for the program aspects of maintenance, improvement, appearance of the grounds and so on. Involve them in this program, he said; don't let them simply push papers around, write the requisitions and see that the budget gets sent out in four copies. If the superintendents would make such people partners in the program they could make an enormous contribution.

Freedom in a hospital means not



A pleasant environment makes "quiet activities" more meaningful because the patient feels at home in surroundings such as he might find in the community. Curtains, pictures, books and rugs help his cure and improve his behavior.

just the freedom of opening doors, but freedom from unnecessary restrictions, perhaps behind locked doors. When a ward or a hospital is locked, fewer restrictions may be needed within the ward or the institution, and it is therefore possible to set up a kind of community more analogous to life in the outside world.

There is a good point in the value of physical limits in creating a situation in which the patients can be free, said Miss Ridgway. As mentioned in a previous discussion, the patients' capacity for accepting responsibility affects their treatment in an open situation. In an OT shop, one patient could not work as long as the door was open; he was anxious, tense and restless. When the door was

closed he was able to relate to other people and work productively. From the point of view of the staff member who takes twenty patients on the grounds where there are no barriers of any sort, his time is employed counting patients' noses. He is not able to relate with them. He is not able to encourage them in activity. He is not able to create a therapeutic situation. On the other hand, if the same worker has the same group of patients in an enclosed area he can, in this same situation of reduced necessity for intense observation, perhaps encourage a volley ball game or help them to relate in one way or another. The anxiety felt by the employee changes the situation materially.

There are hospitals with large, park-like grounds where perhaps hundreds of patients have grounds privileges, but simply regress on these privileges, Dr. Anderson pointed out. They wander about and hallucinate, talk to the benches and the trees, and get no better. Planned and meaningful activities, in or out of the buildings, would be more therapeutic. Better than "park-like beauty" would be a recreation area for patients to play games or take part in sports.

Hospital versus Community Adjustment

Then there are the patients who have grounds privileges, have made a fine adjustment, and don't want to go home, said Dr. Peterson. We say they have become institutionalized. We have probably adjusted them to the hospital environment and the fine grounds, instead of preparing them to go back to the average community six-roomed house with a pocket-handkerchief lawn alongside their neighbor's.

His hospital, Eastern State Hospital, Tennessee, tried the bold experiment of a summer camp project, right away from the hospital, for long-term chronic patients who were apparently in a state of remission, following treatment with the new drugs. The group was half men and half women. There were no bars, no locks at the camp. Employees and patients dressed alike and shared dormitories.

Men and women patients swam together, danced together, attended classes and all sorts of recreation together. The superintendent declared that the first night he was very frightened and didn't sleep well! But after the first few days, the patients were relaxed, and participating in this entirely normal community atmosphere whereas before, when they had been on leave, or even discharged from the hospital, they had returned in considerable numbers because they had not been adequately prepared to adjust to ordinary community living. This hospital hopes to inaugurate a year-round "community type" program so that the chronic patients can be oriented for their return to normal society.*

* See *MENTAL HOSPITALS*, Nov. 1955, pp. 8 & 9. "An Experiment in Living"—Peterson & Acuff.

Then there is the question of whether we should place personnel quarters on the grounds of a hospital—physicians' residences, nurses' and aides' quarters and so on? In a metropolitan area this should not be necessary. Some feel it detracts from the hospital grounds to have that area set aside and forbidden to patients. True, in case of emergency, staff people have to get there very quickly. But with modern transportation, the hospital can quickly be reached by employees who do not live on the grounds. On the other hand, situations vary considerably with the isolation from or presence in large metropolitan areas. In some isolated hospitals, you couldn't get personnel unless you provided quarters.

Many discussants had, it was said, graduated to the superintendent's home, but they have a vivid recollection of the quarters assigned them when they first came to the hospital. It made them, as young doctors, feel inferior—not expected to take leadership, in their profession, in the local Lodges or in the various churches. If a new physician arrives and is put in a slip of a room, with furniture totaling not over a hundred dollars in value, said Dr. Sutton, you don't have to tell him what you think of him; you've told him better than you could tell him any other way that you have little respect for him.

Facilities, Respect and Turnover

Attendants and nurses are even worse off. And yet we wonder why we don't get good employees to operate these liberal programs we are talking about, why the turnover is so tremendous, and why we don't seem to be getting anywhere. And we are angry with the community because it doesn't respect the institution, nor the staff—the staff which the hospital doesn't itself respect.

Some superintendents like to have employees living on the grounds and some do not. But if they do live on the grounds they must be provided with some means of entertainment and sports activities, and some other facilities, such as personnel shops, barbers and so on, in addition to nice furnishings and attractive surroundings.

If the facilities provided are excellent, as they should be, then the individuals for whom they are provided

should pay for them, suggested Mr. Dorsey. In this way you get a more independent type of employee, create greater independence by making their living their own responsibility and hopefully get better and more independent contributions from them in their work. It is true, of course, that some individuals who live on hospital property will take less care of it than they would their own. Also, decisions and preferences are influenced by whatever ruling the State revenue office has made regarding income tax on maintenance.

What Are We Guarding Against?

Then there is the question of guardhouses at the hospital gates. They exist on the grounds of many hospitals. What are they guarding against and against whom? It seems paradoxical that while we discuss greater freedom for patients we still tolerate our guardhouses.

Yet at some institutions hundreds of car drivers will detour to ride through the grounds and sightsee. There is the question of the protection of the employees and the patients from the public rather than the reverse. We don't want people to come and gape curiously at the "psychos" or "nuts." Public relations bears very closely on this whole question, said Dr. Bloomberg. We should ask what is wrong with having people come through our grounds and see our hospital. Isn't this one of the desirable things, so that people will not "isolate" us and know that we are not dealing with raving maniacs but with people whose mental illness is curable? That our hospitals are like general hospitals where people come to be cured of their sickness and then go home? Don't we want them to understand that we are not keeping our patients in hopeless dungeons? That we do open up to the community, that we want them to come and see what we are doing? That we are not on the defensive about it?

Those of us who are able by whatever means to attract not three or four, but thirty or forty people with no business except the fact that they are citizens who are paying for this service and would like to see what they are getting for their tax money are doing a better job of public relations than those who can get only one or two or none at all.

Administrative Aspects of Patient Freedom

Chairman: Harrison S. Evans, M.D., Ohio

Discussion Leader: I. L. W. Clancey, M.D., Sask., Canada

Presentation:

In our present discussion, freedom may be equated with situations in which the patient has an opportunity of making a choice—whether to accept parole, whether or not to work, and so on. Because of our function of protecting public and patients we must initially restrict freedom to some extent, but restrictions should be applied after reaching, where possible, a consensus with the patient himself. Without a consensus the necessary restrictions should be applied, though not by fiat.

Administrative measures can be developed which progressively increase the patient's area of choice and still protect him and protect the public. There are five problem areas:

1. The first, problems associated with admission: methods of committal, safeguards against wrongful and unnecessary committals; the reception of the patient in the hospital and specifically the conflict between activities directed toward maintaining the self-esteem of the individual as opposed to those directed towards the patient's hygiene, recording of his property and other necessary administrative procedures.
2. Next, the problems associated with the patient's stay in the hospital: patient government; what we do about staff opposition; how to get the patient to take part in patient government; the use and abuse of privileges; the control of patients; safeguards against suicide, elopements and accidents, and lastly, the acceptance and recognition of the risks to the patient and the community.
3. The problems associated with discharge: boarding-out programs, parole as opposed to direct dis-

charge, the function of the social service department.

4. Liaison with the public: the preparation of the family and the community for extended freedom which may lead to elopements, accidents, and so on.
5. Finally, the problems associated with the hospital personnel themselves: the conflicts between the lay and the professional staff arising out of different attitudes and goals; the conflict between the senior administrative medical staff and the "therapeutic medical staff" arising from the proximity of one—the administrator—to the general public, and of the therapist to the patient; the loss of status felt among nursing staff as expressed in the fear that the "doctors and patients will gang up against us."

Since the changing and improving of both staff and community attitudes seem to have been a keynote of all our discussions of patient freedom, I hope somebody will be brave enough to get up and give us some ideas as to how we should tackle this problem. What experiences have any of you had with your staff groups in helping to change and improve staff attitudes? Do you know who are the standard bearers among your hospital staff? These are the people we have to educate. If we can educate this group, usually quite a small one, our education program will expand. But what particular staff group should be tackled first, and which particular group in the community?

Discussion:

Participants: C. A. Buck, M.D., Ont., Canada; Paul Haun, M.D., Pa.; Mr. Robert Klein, Ill.; Simon Kwalwasser, M.D., N. Y.; Harold L. McPheeters, M.D., Ky.; H. C. Moorhouse, M.D.,

Ont., Canada; James W. Murdoch, M.D., N. C.; Chaplain Moody A. Nicholson, Okla.; Walter Rapaport, M.D., Calif.; Reginald S. Rood, M.D., Calif.; Hon. Harry Shapiro, Pa.; William S. Simpson, M.D., Kansas; Mrs. R. R. Tamargo, N. Y.; Mesrop A. Tarumianz, M.D., Del.; G. D. Tipton, M.D., Calif.; Mrs. Marion S. Wells, Ohio; Samuel Wick, M.D., Ariz.

The main problem is that the community, and therefore, the politicians have not been educated to understand our financial needs, said Dr. Tarumianz. We must have sufficient money to obtain the services of psychiatrists, nurses, social workers and technicians in all areas. And it is obviously the consensus of the group that to implement patient freedom and progressive patient responsibility, more staff and better trained staff, rather than less staff, is needed.

We should tell the people about our defects, because these will be advertised and publicized. We should tell our communities at home that this Institute believes that there are great possibilities for improving conditions in our hospitals and our clinics, if they will just give us the opportunity.

Invite Legislators into Hospitals

Mr. Shapiro said he had learned that all the doctors seem to have found the answer as to what to do for the patients. But all their knowledge and all their good intentions would accomplish nothing unless they realized that most people—and certainly legislators—don't have any imagination! People say that the hospital superintendents have been overpowered by politics and that nothing can be done about it. "I simply do not believe it," said Mr. Shapiro. "You can do something about it by going into the practical end of matters, and telling the

The social worker increases in importance as more patients are discharged because of new therapies. The work of this department concerns the patient's hospital life as well as her family situation and her discharge. A good social worker begins her contacts with the patient as early as possible.



people who hold the purse strings just what you need. Invite the legislators into the hospitals and let them judge the case in the forum where it belongs!"

Mr. Klein said too few studies had been made to determine whether the increase in per capita appropriations has indeed increased the discharge rate in mental hospitals; yet every year, this argument is presented to our legislatures. There is little information solid enough to present on an impressive scale.

In Ohio, Mrs. Wells said, after the General Assembly listened to a psychiatrist's address, the Legislature set up study committees that went into the hospitals and saw for themselves the deplorable conditions which had been described. As a result, they had a ten million dollar increase granted over the amount requested by the Governor for personnel and that part of a bond issue, which was for mental hospitals, was passed by the citizens of the state.

Concrete, Ethical Pressure

There are three concrete methods by which hospital administrators can bring ethical pressure to bear upon their communities, said Dr. Haun. He listed them as follows:

1. It is possible for any hospital to set up a model ward, adequately

staffed and equipped, focussing resources in that one area. Thus a demonstration can be given of what can be done; you also create terrific pressures within your own hospital staff to have comparable improvements throughout the hospital.

2. The second method is to invite legislators to visit the hospital and show them the worst wards you have. Perhaps they will forget; usually they won't. It makes an important breach in the wall of ignorance.

3. The final thing is to establish a well-coordinated, carefully engineered volunteer program; important members of the local community who actually know what is going on begin to feel personal responsibility for patient care, and can be most effective missionaries.

In relation to the hospital administration as it affects patient care and freedom, several physicians mentioned the importance of admission procedures designed to give a new patient the feeling that he is being treated as an individual; thus single admissions are better than large group admissions, so that the new patient can become acquainted personally with the people who are going to take care of him on the ward. Voluntary admission, where the law permits it, helps considerably but, said Dr. Buck, even if the patient has been certified by a

magistrate, he must be dealt with in exactly the same manner as other patients who may have been sent in on the certificate of two physicians only.

While undoubtedly the community attitude has a lot of influence over what privileges patients may be granted and how extensive those privileges shall be, the administrative problems connected with them largely revolve around the judgment of the staff. This especially applies to grounds privileges—who shall have them, when they shall have them, and so on. Dr. Tipton said that in his hospital he had alcoholics who needed control, mentally deficient girls with poor judgment, and so on. The chief problem, he believed, was the proper indoctrination of all personnel from the top to the bottom, as to what calculated risks might properly be taken.

Information from Nursing Staff an Important Factor

The importance of securing information from nursing staff regarding the degree of freedom an individual could handle at a given time cannot be over-emphasized. These people spend more time with individual patients than do doctors, so their information and opinion is of great assistance.

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So, too, is the judgment of the patients themselves. Dr. McPheeters described how his hospital went about opening wards. The patient government group was informed that the administration was considering the opening of a certain ward. They were allowed to discuss this for a time to see what they thought about it. If they felt that they could take the responsibility of guarding against escapes and other serious incidents, they told the administration so. If on the other hand they felt that they should work out some problems among themselves first, the ward remained closed until they felt ready. Under this system, from 30% to 40% of all the wards were opened during a six-month period.

Freedom to Do Something

When we plan upon opening wards, said Dr. Simpson, we should remember that patient freedom in itself never cured anybody. Freedom in itself implies freedom *to do something*—to make choices of work, of occupation, of recreation, whether to elope or not, how to handle the situations which arise out of liberty. This implies not that we need less staff, but that we need more and better-trained staff.

Here the volunteer fits into the program and Dr. Simpson described his "Golden Link Club"—a patient self-government group, into which the volunteers were invited. These volunteers took the patients out to their homes. There are patients, said Dr. Simpson, who after years in hospital, don't know that there are such things as street lights, that Red means Stop and Green means Go. The volunteers take them for bus rides, on shopping expeditions and on home visits, to get them used to community living again. If something active is not done, then the patients who are on an open ward may be harder to get out of the hospital than any other group of patients. The more freedom you give patients, the more you have to make opportunities for them to utilize that freedom constructively.

In California, volunteer workers, in addition to taking patients shopping and on home visits, also try to find jobs for people who, in the judgment of the staff, are ready for discharge. Money was provided through a special fund to provide temporary homes for such patients after discharge.

In any discussion of discharge, of course, the social service department is involved. Dr. Clancey said that a

hospital that had a non-existent or an inadequate social service department implied that it did not believe that patients do recover or should be discharged. The provision of adequate social service is therefore mandatory in any hospital which is attempting to increase patient freedom in such a way that it will lead to patient discharge.

Experiment in Staff Education

Dr. Moorhouse described an experiment which his hospital undertook in staff education. The psychology department prepared a document, rather like a questionnaire, directed at finding out exactly what the patients thought about the staff. There were some very remarkable answers! Next, staff members were shown as many professional-education films as possible; next, the administration had recordings made, unknown to the participants, of staff-patient situations. The discussion of these recordings later, in an unbiased and friendly atmosphere called for delicate handling—but as a result of the total program, staff members learned a good deal about their own relationships with patients, and were able to apply this knowledge constructively.



Activities designed to improve social adjustments as well as for enjoyment make freedom meaningful. To a woman, the freedom and facilities to wash and iron her own "small things" is a natural activity of great importance to her.

Forensic Psychiatry

Discussion Leader: Henry A. Davidson, M.D., N. J.

Presentation:

Dealing as they do with social deviation, law and psychiatry seek a common ground. Law must respect precedent; otherwise a man would never know what his rights would be tomorrow. But psychiatry, being part of the rapidly advancing front of medicine, must use each new and useful finding as it is developed. The decisions of 20 years ago may still be solid law. The treatments of 20 years ago are likely to be poor medicine.

Medical ethics traditionally focuses on the duty to the individual patient. But the psychiatrist must give priority to a duty to the community. In the mental hospital, these duties may clash. The patient might be better off with a driver's license, unrestricted freedom to come and go and the right to carry a revolver. But the community's welfare may require that these be denied to the patient. What does a hospital officer do when placed on the horns of such a dilemma?

A similar problem is presented with respect to confidential statements. If, in confidence, the hospital officer learns of a patient's plan to commit an assault, where is the doctor's duty? In some jurisdictions he is legally bound to report this and in others he is forbidden to report it. And what ethical guide does the psychiatrist or other mental hospital official have?

Our patients are weak, and we have a duty to protect all their natural rights and all their constitutional rights. But we must not overstep the frontier which separates those rights from our duty to protect public welfare.

This has public relations aspects too. Have we oversold psychiatry to the point where the public expects us to explain away all abnormalities and to wipe out all oddities of behavior? Do we lose caste with the public if we experts fail to work such miracles?

We are deeply involved in the criteria of criminal responsibility.

Shall we go along with the rule in McNaughten's case? Or is the recent decision in the Durham case more in keeping with 20th century psychiatry?

Here, for instance, is a headline from a recent newspaper. It reads: "Released from Mental Ward Eight Times, Man is Seized as Attacker."

A twenty-five year old man was held without bond for raping a forty-five year old woman. The rape is not held to be evidence of mental disease, but the fact that he was eight times in a psychiatric ward and each time released makes the average reader assume that psychiatrists did not know what they were doing! The psychiatric ward could not do anything but release him because he was not committed as a psychotic. The public does not understand this.

Are we suffering here from a defect in our public relations? Or have we failed to educate the public about our limitations?

Suppose that a voluntary alcoholic patient is about to leave your hospital. You are sure that when he gets drunk, he will get assaultive and do some damage. What can you do in the present state of the law?

Discussion:

Participants: Wilfred Bloomberg, M.D., Mass.; M. D. Campbell, M.D., Wash.; Mr. Elias Cohen, Ind.; J. Berkeley Gordon, M.D., N. J.; Simon Kwalwasser, M.D., N. Y.; Mr. James Lister, B. C. Canada; J. A. Mendelson, M.D., Ohio; H. C. Moorhouse, M.D., Ont. Canada; Harold A. Pooler, M.D., Me.; Walter Rapaport, M.D., Calif.; Reginald S. Rood, M.D., Calif.; John T. Shea, M.D., Mass.; F. L. Spradling, M.D., Neb.; Samuel Wick, M.D., Ariz.

In Ohio, a patient who had been committed made an ostensibly good adjustment and was released. He was returned and, after observation, discharged again. After one day, the police brought him back. He was kept for four weeks. He knew "the nature and quality of his acts." Once

more he was allowed out and this time three policemen brought him back. He is not legally insane. The only responsibility the superintendent has is to notify the court; it then becomes their responsibility.

Here is a bus driver in the hospital voluntarily, after a weekend of drinking. Staff opinion is that this alcoholic may drive while drunk and jeopardize the lives of forty people. But he is not psychotic. And he is a voluntary patient. What do we do?

Withdrawal of Driving License

In Ontario, in such a case, said Dr. Moorhouse, the superintendent of the hospital reports to the Department of Highways, saying that the individual is going home "on probation" but that he is unfit to operate a motor vehicle. The Department of Highways is then responsible for revoking his license if they see fit.

Dr. Rapaport said that in California, the Department of Motor Vehicles watches the commitments and notifies the hospital to pick up the patient's driving permit. In New York, the law demands that a hospital notify a federal agency on releasing a drug addict. In New Jersey, the state hospitals have agreed informally, with the Motor Vehicle Bureau, that psychotic patients on pass, visit or parole, shall not be permitted to drive cars during their year of "parole." Each week, superintendents advise the Commissioner of Motor Vehicles of patients released "on parole." Each time that such a patient is definitely "discharged," the Bureau of Motor Vehicles is notified that the ex-patient is now considered competent to operate a motor vehicle, if that is the case.

This agreement seems to be in the best interests of the public as a whole, said Dr. Gordon, who described the procedure. If a patient on "parole" or "trial visit" status were involved in an auto accident there would be a serious question of insurance liability.

Also, there are unpleasant public relations implications for a hospital which takes no steps to prevent an "insane" person from wielding a two-ton monster capable of hurtling down Main Street at a mile a minute. After all, a patient on pass, visit or "parole" is as much the responsibility of the hospital as if he were still within the walls of the institution. The decision to forbid driving is made by the Bureau of Motor Vehicles. The hospitals simply notify the Bureau of the facts.

In British Columbia, said Mr. Lister, every patient, voluntary or committed who comes into the Provincial Mental Health Service surrenders his driving license. If he is released on six months' "probation" he does not get his license during that period. Once the patient is fully discharged, it is his problem to get a driver's license again. The authorities retest him to see if he qualifies.

Dr. Bloomberg resented the assumption that people who had been mentally sick should not drive. What about the patient on trial visit who is unable to make his living as a farmer, because he may not drive a tractor across a public road from one piece of his land to another?

In Massachusetts when a patient is committed, the hospital has to pick up his license and send it to the Registry of Motor Vehicles, which automatically suspends the license. But it is assumed that a voluntary patient is well enough to keep his license. Recently, however, the Commissioner instructed all superintendents that in the event that a patient's livelihood depended on his operating a motor vehicle, superintendents should do their best to enable him to get it back when he is discharged. They usually notify the Registry of Motor Vehicles and say that they consider this man to be capable of operating a motor vehicle.

Usurping the Law's Functions?

Mr. Cohen wanted to discuss retention of a person who, a psychiatrist might feel, was "potentially" dangerous, in that there was a possibility of recurrence of a violent or unsocial act. Can we—should we—incarcerate a man on the basis of a "probability" that he will do something? Even under habitual criminal law, there must be



a demonstration of repeated *acts*, not mere possibilities.

The courts and legislatures, said Mr. Cohen, have really not defined "insanity" or "psychosis" with any precision. He wondered if psychiatrists are not trying to fill that vacuum by assuming, in a sense, the prerogatives of a court and making legal decisions about sanity. The law provides, in careful detail, a number of legal safeguards. Are psychiatrists substituting their judgment for these legal rules?

The Chairman asked if Mr. Cohen, in effect, wanted it both ways. On the one hand he wanted the psychiatrist to give unequivocal, clean-cut decisions about diagnosis and prognosis; on the other hand he wanted the psychiatrist to avoid making decisions which touched on legal rights.

There is, the Chairman continued, a large overlapping area including decisions which are essentially administrative or judicial rather than medical. But the judge can reasonably ask the psychiatrist: "Do you think this act of self-exposure is likely to lead to rape or homosexuality?" The psychiatrist can hardly say: "No comment: that is a legal question."

The court and the public will then take the position "Psychiatrists are no help." The judge may ask "This medical opinion you have given me—that the man is suffering from an obsessive-compulsive reaction—this is all very interesting, but is he likely to be assaultive?" Each one bounces the ball back to the other.

Mr. Cohen asked if psychiatrists were in agreement as to what constitutes a disease which renders a person committable and warrants his removal from society. He also asked about the intolerance of the community towards an individual, who while not dangerous, and perhaps not even psychotic, was nevertheless a nuisance?

Dr. Davidson said it is scarcely surprising that doctors disagree in replying to that question, since the U. S. Supreme Court sometimes splits 4 to 5 in interpreting laws written by other men! On the whole, he said, there is general agreement that a person ought to be committed if he is dangerous to himself and to others. If he is not dangerous, but only a nuisance, we simply leave it to the court to decide whether to restrain him.

There was some feeling that it was "unscientific" to have different legal yardsticks of insanity to suit different situations. But Dr. Davidson said that the criteria of competency to make a will are different from the criteria to determine criminal responsibility, that the measure of the need for restraint was not the same as the measure of competency to endorse a check, and that the law was perfectly realistic using criteria specific for the particular situation.

Dr. Bloomberg said it would be a fallacy to require agreement as to what diagnosis should constitute commitment, since commitment is by its very nature based on a pattern of behavior, and not on a diagnosis. The question is, regardless of diagnosis, whether this particular pattern of behavior promises to be so dangerous that the individual must be committed.

Doctor-Patient Relationship

Regarding doctor-patient confidences, Dr. Davidson said that with a dangerous patient, his own reaction was to do what had to be done to prevent the danger even if it did mean breaching a confidential relationship. In a sense, it is in the patient's own interest to have him arrested and then committed rather than to let him go out and perpetrate a murder. In this light, there is no diversity between the patient's welfare and that of the community. There was general agreement in the group that, when closely examined, many of the apparent diversities of interest vanished.

One of the legal lags, it was pointed out, was in the requirement that a patient be dangerous before he could be committed. Dr. Rapaport said that in California this issue had been effectively met by the rule that the criterion for commitment was "need for treatment" rather than danger. In such a case, the only right the patient might lose would be the right to drive a car.

If a voluntary patient demands his release, a California hospital will not let him go if he is dangerous. The hospital, in fact, may take steps to process the patient's formal commitment. They do so without fear of lawsuit, because they are legally protected in such cases unless it can be shown that something egregiously

negligent or downright fraudulent was done in connection with the commitment. They are permitted to hold a dangerous voluntary patient for seven days. This gives them time to work something out.

Dr. Campbell said that he was threatened with the transfer of thirty convicts from the State Penitentiary who were not legally "insane." They were all psychopaths. Could he force treatment on such persons? The matter involved the privacy of the person of legally competent individuals.

In Nebraska, in a similar situation, said Dr. Spradling, they were careful not to impose treatment upon those who had not been committed as "insane."

Medical and Lay Concepts of Disease Differ

Dr. Davidson said that the word "disease," as the layman uses it, means something which falls upon an innocent individual. He is a victim. This is the lay concept. But to the physician the word "disease" means any deviation from the normal. Statistically most people are not burglars, and therefore a man who is a burglar has by definition a "disease" in the sense that he differs from the normal. To the layman, this is not disease because this is not something which falls upon an innocent man, nor can it be treated medically. Again, from the layman's point of view, alcoholism is not a disease, but rather a bad habit. From the physician's point of view, alcoholism is sickness. And it is this disagreement as to the meaning of the word "disease" which causes much of our difficulty. Thus a judge picks up a medical book and says: "It says here that alcoholism is a disease. You are experts in treating disease. Why can't you do something for him?"

We say, "Well, it's not exactly a disease; it's a personality disorder." And we have caught ourselves in a semantic booby trap.

Non-Psychotic Offenders

On the question of the psychiatric treatment of non-psychotic offenders—sex psychopaths, juvenile delinquents, alcoholics and others—the problem of the administrator of a mental hospital or a maximum security hospital is to protect the institu-

tion as a hospital, and not to turn the place into a prison. The essence of the distinction, said Dr. Rood, is to agree that a psychotic person belongs with us. But the non-psychotic, dangerous person does not necessarily belong with us. He might equally belong in a prison. The superintendent of the hospital should have choice about which non-psychotic persons he can treat.

Longevity of McNaughten's Rule

The question of the rule in McNaughten's case again came up. The Chairman pointed out that this century-old rule has two components. First it has to be shown that the defendant has mental disease or defect; second, that this mental disorder made it impossible for him to know that what he was doing was wrong. This rule has been a favorite target of psychiatrists for many decades but no one has yet conjured up a better one. The chief objection to the rule is that it ignores a large group of mentally ill people who *know* they are doing wrong but who are driven to such wrong-doing by their mental disorder—for instance, compulsive pyromania. The rule in McNaughten's case gets its longevity from the fact that it comes very close to the popular concept that a person should be held accountable for doing what he knows he should not be doing. The most recent attack on the McNaughten rule is found in the District of Columbia in the Durham case, where the Court of Appeals said that the rule ought to be this: "An accused is not criminally responsible if his unlawful act was the product of mental disease or defect." Since we psychiatrists say that alcoholism is a mental disease, it would appear that under this test a sane alcoholic could commit a murder and be "not guilty" if the murder was the product of drunkenness. But being sane, he could not be committed. As yet only one court in one jurisdiction has adopted this formulation, and because of this obvious loophole, it is unlikely to be widely followed. Conceivably this gap might be plugged by legislation permitting commitment of sane persons who are acquitted under this rule. But even then, the hospital would be harassed by need for keeping a sane person forever locked up in a minimum-security institution.

Group Session:

Malpractice Insurance

Discussion Leader: Hon. Warren E. Magee,
A.P.A. Legal Counsel
Washington, D. C.

Participants: Daniel Blain, M.D., D.C.; Philip Brown, M.D., Mich.; Charles Buckman, M.D., N. Y.; George W. Davis, M.D., La.; Theodore Dehne, M.D., Pa.; Mr. Bernard Dolnick, Ind.; Walter M. Gysin, M.D., Ky.; Jefferson F. Klepfer, M.D., Ind.; H. A. LaBurt, M.D., N. Y.; J. Martin Myers, M.D., Pa.; Mr. Don Phillips, Va.; G. Wilse Robinson, Jr., M.D., Mo.; Mrs. Dorothy T. Shelley, Pa.; Herman B. Snow, M.D., N. Y.; George P. Wyman, M.D., Ky.

During recent years, suits for malpractice have grown by leaps and bounds. Last year the loss ratio against the previous three years in the District of Columbia increased by 150%, accounting of course for the great increase in rates.

Malpractice may be defined as the failure on the part of the physician to properly perform duties which devolve on him in his professional relationship with his patient, a failure which results in some injury to the patient. Malpractice is tested by the conduct of other physicians skilled in the same field in a given community or in a similar community. Negligence is kin to malpractice and is a failure to perform a duty you should perform or the doing of something in a careless manner, causing injury to the patient. The terms are almost synonymous.

We are concerned especially with the responsibility of mental hospital administrators. Today in many states the public hospital may be sued—even if it is a charitable hospital—if anyone is injured therein. The hospital has the duty of selecting a proper staff, of employing qualified medical men, nurses and administrators. If a patient is injured through the presence of and because of the act of an incompetent person, the courts hold that the hospital is liable. However, when a doctor only has privileges in a hospital and is not employed by it, a

different problem is posed. In this case, the hospital is usually not liable.

The question which concerns us is what hospitals can do to protect their staff? In the past, policies written by hospitals have not been adequate to protect all of the staff employees. A usual type of policy covered only the hospital, its director and its officers. Others in the hospital were not covered. Thus the insurance carrier might not be obliged to defend a physician or a nurse, and there have been cases where staff members have been sued personally because the hospital coverage was not broad enough to protect them.

Split Coverage Unwise

Today we realize that it is unwise to split our coverage between carriers and this applies especially to private hospitals. If you have a public liability policy with one company and malpractice insurance with another, the hospital may find that neither carrier will defend in a given situation, each contending that it is covered by the other's policy. This might mean that the hospital itself would have to defend the action. A case of negligence, for instance, might be covered by the public liability policy. Or the act might be a part of the practice of medicine which would mean that it might be covered by the malpractice policy. Such borderline cases cause trouble.

Many feel, therefore, that the hospital should have adequate coverage by a single carrier, which covers all persons assisting in the hospital, even down to the student nurse. Otherwise, you may reach the point where the hospital doctor will be reluctant to undertake a procedure which he feels is necessary, because of the risks involved, and against which he has no insurance. In this case, the patient will be the one to suffer.

It is true that it is getting more and more difficult for an institution to be

Ed. Note: Although this session also took the form of free discussion, the leader, Mr. Magee, was in the position of the expert. Thus most discussion took the form of questions or examples—i.e. "What should one do if—." This session, therefore, is presented in the form of an article on the topic.

covered by comprehensive malpractice and liability insurance. The rates are going up. Hospital physicians who are members of the American Psychiatric Association may be eligible to participate in the malpractice insurance plan of the Association, which is a group plan, if group plans are permitted in the states where such physicians practice. If there are any physicians who have not been able to obtain insurance, they should contact the Association in Washington to ascertain whether insurance can be obtained for them under the group plan.

Group insurance, where permissible, benefits the individual. If you have an individual policy and have a series of mishaps and a judgment has been obtained against you, your insurance company is at liberty to cancel your policy and you may have great difficulty in securing another. Under a group policy this right to cancel can be restricted in the physician's favor.

The case of a patient injured apparently deliberately by a hospital employee (one participant described such a case) was discussed. If, as in this case, the evidence was circumstantial and the matter could not be proved beyond a reasonable doubt, a criminal prosecution for this assault



could fail. However, the administrator need not be obliged to keep the offender in the absence of a tenure status, the reason being that employment is personal and is usually terminable at the will of either party.

A hospital is required to exercise reasonable care and to perform the services which it tells the public it is able to perform. In so doing, it must exercise reasonable care in the selection of its staff. It must ascertain for instance, that a physician in the hospital actually is a physician. It may be liable if it did not exercise this reasonable care in hiring physicians or in permitting physicians to come into the hospital and exercise privileges. If the hospital has reasonable regulations and they are administered reasonably and not incompetently, then it should not be liable.

Insurance companies, from their experience and their tabulation of costs feel that electroshock, like X-Ray, is more dangerous from a liability point of view when compared with other fields. Therefore premiums are higher. We all know that injuries can result from shock and X-Ray treatments. One may be held liable for the injuries which resulted to the patient in these fields.

Consent Helps Defense

Consent to operative and treatment procedures is important to the defense of the doctor. Some persons can legally give consent on behalf of a patient who cannot consent for himself. You have to make up your mind, as a psychiatrist, whether your patient is able to consent himself. If not, you should obtain the consent of the parents if they are available, or of one parent, or of a legal guardian, if a minor is involved. The superintendent is *not* the guardian of the patients under his care. He can only be in a doctor-patient relationship. Only a small number of patients are adjudicated incompetent by the courts. But if you feel that the patient is not capable of consent, then you should get the consent of the wife, the husband, the children or the guardian, in writing, to show that you did the best you could. If the patient is able to give you consent, and is an adult, that should be sufficient. If he has the mentality to refuse, he has the right to refuse, even against the consent of

the family and against your own professional judgment. Consent is a contractual thing. If the patient has refused the treatment, and you do it even with the consent of his wife, he can sue you and may be able to recover. You might make a good impression on the jury and might win the case, but legally there would be liability.

Consent No Defense for Malpractice

Consent does not protect against malpractice or negligence. But if you have to defend something you did without consent, you are in an even worse situation. You cannot depend upon a contract absolving you in advance against malpractice or negligence—that would be against the public interest. But if you have consent to administer EST and get a bad result, provided you can show that you did what you did in accordance with good practice, that no act was done unlawfully, you should win. There should be no liability against you because there was no bad conduct and no negligence on your part.

Psychiatrists as individuals can get good malpractice coverage and many do through the A.P.A. master policy. The question has been asked whether it is necessary for all members of a hospital staff to have insurance individually or whether they can derive protection from the fact that they work in a certain type of institution, which can be proved to be operating on a competent basis. It would be wise for the doctor or other person to ascertain the extent of the coverage of his institution to determine whether the policy insurance covers his particular functions. Since policies can be changed or cancelled overnight, however, it is wise for any practicing physician to carry his own malpractice insurance for his own peace of mind. Further, he may have an emergency situation away from his hospital, where he would not be covered by the hospital's policy, which an individual policy would cover.

In certain states, New Jersey, for instance, it was said that you cannot sue the State. The legislature would have to pass an act to permit suit to be brought. Nor will the State insure hospital employees individually. Nor does the law state that physicians employed by the hospital must be li-

censed to practice in New Jersey, provided they are licensed to practice somewhere. If something goes wrong, therefore, the superintendent could be held responsible. The only protection is for him to carry insurance.

In some policies the mental hospital administrator is excluded and the insurance companies regularly exclude everybody who comes under Workman's Compensation Act. It was said that in Michigan, none of the state hospitals have coverage per se but the State's Attorney General goes in as their attorney to protect them if they are sued. The Department of Mental Health attempted to get coverage for the hospitals, and sought a law to protect the staff members of a state hospital, but the legislature did not pass it.

Secondly, the Department tried to obtain a blanket over-all policy paid for by the Executive Department covering all state physicians, but could not get the necessary money from the budget department. At present, there is no adequate coverage. The Department has been unable to get adequate insurance for administrators. Two companies will give ordinary adequate coverage if electroshock is not used, but these two companies specifically do not cover the administrator of a hospital. The administrator because he heads the hospital, thus could be sued if a plumber dropped a wrench on a patient's toe.

It was stated from the floor that in Kentucky if a physician in a state hospital decides that electroshock is indicated, then the permission is automatic. If the legislature specifically gives the authority and orders it, then the physician in administering state law might be protected against a claim of non-consent.

Certainly it would be desirable for mental hospital administrators if their legislatures would pass a law, stating that they, like coroners, were immune from suit in the pursuit of their official duties. Such legislation should be so worded that the patient on entering the hospital would be considered to have consented to the hospital procedures in the situation. The question, of course, remains whether such a law would be constitutional.

As a matter of interest to the profession, in some areas 30 percent of malpractice suits come about because

of some chance remark made by a member of the profession itself. This situation could be alleviated by not making adverse comments about the treatment given by other members of the profession. Chance remarks by anyone connected with a hospital—an intern, a nurse or a resident—can also sow the seeds of a malpractice suit. While in certain states the hospital itself might be immune from a malpractice suit, the physicians and persons practicing in that hospital usually are not. Thus every person working in a hospital with patients should have malpractice insurance if he can obtain it.

Recommendations

The Discussion Leader concluded by reading the following constructive suggestions, developed by the Hospital Council of the National Capital Area:

1. Write specific orders, giving the correct name of medication and amount, strength of solutions to be used, frequency of administration, where and how the preparation is to be administered. All internal medications should have the route of administration indicated: P.O.—I.M.—I.V.—S.C., etc.; external medications, the area to which applied.
2. Use the metric system in writing dosages in order to avoid errors that result from converting the dosage to milligrams, etc.
3. The patient's chart should be legible and intact. If an order is written incorrectly, do not erase or mark it over with ink, but draw a line through the order and write beside it "error," then proceed to write the correct order. No part of the chart should be destroyed for any reason whatsoever.
4. Do not change a written order that has already been carried out. If the dosage of a medication is to be changed, write a new order.
5. In writing the order "Resume orders" postoperatively, be sure to check carefully all orders written previously.
6. Do not ask the nurse to take a verbal order except in cases where the patient's life depends upon speed in instituting therapy; then, please write orders for those verbal orders given.
7. Standard abbreviations only should be used; there is a ready

reference at each nursing station to facilitate checking of abbreviations.

8. If a new preparation is being ordered, please inform the house staff and the charge nurse on duty; frequently much time is consumed by the pharmacist and others in trying to locate drugs that may not be available there. Some information about that new drug would be greatly appreciated by those having

to administer it for the first time.

"As previously stated, until better methods are established for dealing with the malpractice situation, members should adhere to the above rules. Results will more than justify the time and effort required to comply with them. It is also within the realm of possibility that if physicians generally cooperate, no further steps will be necessary," concluded the statement by the Executive Secretary.

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The New Drugs (Chlorpromazine & Reserpine): Administrative Aspects

Chairman: Addison M. Duval, M.D., Washington, D. C.

Discussion Leader: Douglas Goldman, M.D., Ohio

Presentation:

Our task this morning is to exchange information about the effects of the use of the "new drugs"—chlorpromazine and reserpine have been the most effective so far—for relatively large numbers of patients in large hospitals. A larger proportion of patients are being treated with them than we have so far been able to treat by other means. This is something which we have all encountered in our daily work with patients, and it seems as if not only the whole service, but the whole hospital has to be reorganized.

First of all we need a new kind of doctor in a psychiatric hospital—one who is not afraid of medicine; who is not alarmed by seeing an eruption which is the result of medication, but who can handle it properly; one who is not afraid if Parkinsonism occurs from either reserpine or chlorpromazine, but who will evaluate it as an index of the activity of the drug, and understand how to control it. Such problems require a new kind of attitude in addition to the psychiatric point of view, and this new attitude we might perhaps call a medical or pharmacologic understanding of what is going on.

This new kind of understanding cannot be confined to physicians. The nursing service also faces a huge new responsibility, because instead of looking after a couple of hundred patients receiving somatic therapy, it is now caring for thousands. How can 20

nurses supervise this kind of nursing? How can they even supervise the attendants?

The administrative aspects of the use of the new drugs may for convenience therefore be divided essentially into the clinical administrative and the business administrative points of view.

Clinically, in addition to educating more medically and pharmacologically sophisticated physicians and nurses, we have to consider how many patients and what kind of patients should be treated by the new drugs because they are likely to benefit. What proportion of our patients can we treat? Can we give 100 patients one pill three times a day with only two attendants working on a ward? And is it possible to extend this treatment to the night shift with only one man on?

What effect does it have on the ward and on the hospital when many patients suddenly improve as a result of the drugs? A patient who has been in restraint for two or three years continuously, only out for the legal number of minutes per day under very close supervision, does not need restraint any more, and yet he is not a well individual. He needs a great deal of extra attention from the occupational therapy department, from the rehabilitation service, possibly from teachers and other people who can re-educate him into useful channels. Vocational rehabilitation may come into existence in many hospitals for almost the first time; the problems of social service in arranging for the pa-

tient to leave the hospital have to be considered. Then multiply this patient by hundreds or thousands. The nursing service, the rehabilitation services, the activities personnel and social service face a monumental task—a task to which they have not been accustomed.

Budgetary Aspects

Moving to the business administrative problems, we are all aware there is a huge rumble to be heard concerning the budgetary aspects. An ordinary, modest drug budget for a state hospital of say 3,000 patients is suddenly increased from its normal \$15,000 a year to twenty times that figure! Instead of giving drugs to two or three hundred patients in small doses, we find ourselves giving massive dosages to one thousand or fifteen hundred; we would like to expand it to two thousand or more because we feel they would benefit. Yet at the same time we are asking money for additional staff.

How can we justify it? At our hospital, for instance, the number of patients in residence on July 1, 1955 was 80 less than on the previous July 1st. There is no other explanation except the effect of this increased treatment.

Another hint was given me by our Social Service Department recently. "There is something very curious going on," they told me. "Like every other hospital we have had patients coming back who have been out on convalescent leave or even on full discharge. Yet in the first eight months

of the use of this medication, 93 patients went on convalescent status who had been treated by chlorpromazine or reserpine and whose medication was continued while on parole. Of these, six have returned to the hospital. During the same period 137 patients were on convalescent leave without the benefit of this outpatient drug therapy, and of this number 57 have returned."

This means that instead of coming back into the hospital the patient is given medication as an outpatient, is supervised once a week, then every other week, then once a month and finally every three months like any other patient on convalescent status. This reflects in the per capita daily and yearly cost.

According to some figures I have, using the most expensive kind of drug treatment, the lowest figure for treating a patient with chlorpromazine would be \$12.24 a month—for 800 milligrams a day. If reserpine works the figure would be about \$9.50 or \$10. This is very much cheaper than even the lowest per capita cost, and if you treated a man as an outpatient for a year it would be cheaper than keeping him in a hospital.

The decrease in destruction of the physical plant, of soiling sheets and so on is more difficult to express in dollars and cents, but it could be done. Then the decrease in restraints—in our hospital restraints dropped from an average 14 and 15 a day to less than one a day during the last three or four months — cuts the cost of supervi-

sion, destruction of clothes, windows, benches and so on.

I will now open this subject for discussion, and we will try to teach one another as much as possible.

Discussion:

Participants: Freeman H. Adams, M.D., Calif.; Anthony K. Busch, M.D., Mo.; Charles K. Bush, M.D., D. C.; Philip N. Brown, M.D., Mich.; M. D. Campbell, M.D., Wash.; George W. Davis, M.D., La.; Mr. Mike Gorman, D. C.; Walter M. Gysin, M.D., Ky.; Daniel Haffron, M.D., Ill.; Franz X. Hasselbacher, M.D., Conn.; John R. Howitt, M.D., Ont., Canada; Granville L. Jones, M.D., Va.; Daniel Lieberman, M.D., Calif.; Rev. Moody A. Nicholson, Okla.; Arthur P. Noyes, M.D., Pa.; Miss Elsie C. Ogilvie, R.N., D. C.; Benjamin Pollack, M.D., N. Y.; Mrs. R. R. Tamargo, N. Y.; Robert R. Yoder, M.D., Mich.

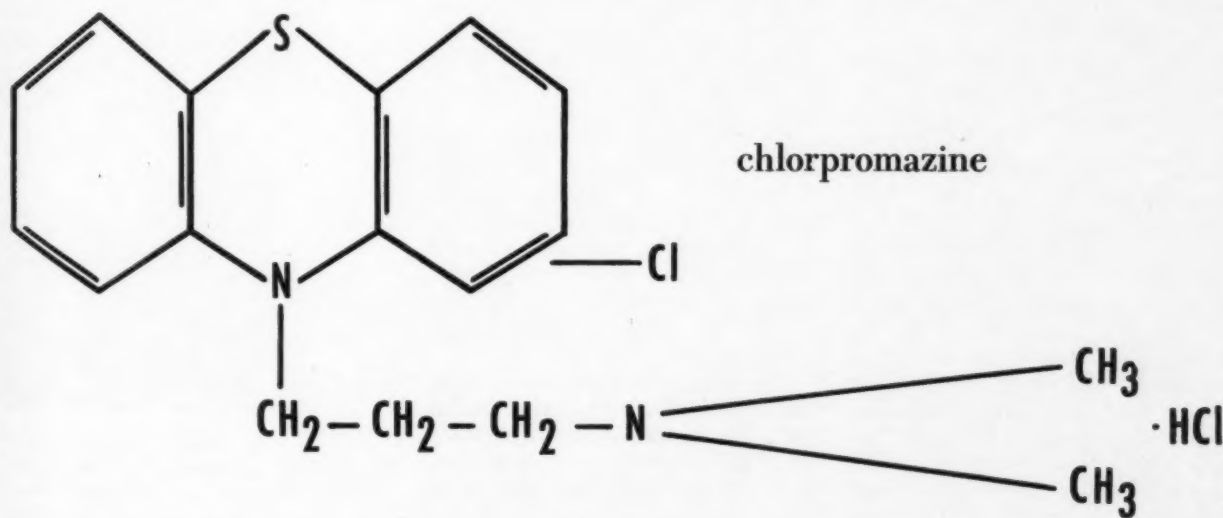
Early in the discussion, questions were raised about dosages, selection of patients, possible risks, side effects and other clinical matters. In his capacity as internist, Dr. Goldman undertook to pass on his experience in these areas. The question of the maximum dose has been investigated in a number of places, one of the most important studies being conducted by Dr. Vernon K. Wright of Houston, at the Baylor Medical Center, who has given doses up to 4,000 and 5,000 milligrams a day. Certain patients do require doses in that range, although there is a greater tendency to produce organic

confusion with large doses. At Longview, the maximum dose used is about 2,000 milligrams, and if larger, patients are put into the medical and surgical wards for closer and more continuous observation. Dr. Campbell of Washington spoke of a patient who received 3,000 milligrams a day and became tractable, but did not lose her delusions. She reverted on a lesser dose.

Reducing the frequency of doses, it was suggested, might solve some of the problems of ward administration. Dr. Pollack said that in long term cases, with small dosages, one dose a day was sufficient, but for larger amounts, twice a day was necessary. Dr. Gysin had tried twice a day doses of chlorpromazine to lighten the load of the nurses, but the patients did not do so well, and they reverted to a thrice daily dose. With reserpine, said Dr. Goldman, since there is a cumulative effect, medication once or twice a day is frequently quite therapeutically effective.

Dr. Jones of Virginia raised the question of side effects. He had a patient with marked agranulocytosis. Although it occurs rarely, should every patient taking the drug have a blood count every week? This would raise quite an administrative problem.

Dr. Goldman said that agranulocytosis occurs only with chlorpromazine. It occurred in four of his patients; one who had had a lymphosarcoma died. A study to be published in the October issue of the *Archives of Internal Medicine* outlines the kind of treatment to



be used. It consists of intensive antibiotic therapy to prevent the infections to which patients with agranulocytosis are subject, and the use of ACTH in fairly large doses to stimulate bone marrow. With this treatment it is not such a threatening condition, although it is important to recognize it early. This emphasizes the need for doctors who are more medically oriented than many psychiatrists are at the present time. Dr. Goldman said he has found that this complication was practically limited to women, but Dr. Jones said that his patient was a man.

Dr. Brown said that he had two cases of agranulocytosis, both of whom died. Both were women, one 62 and the other about 57. The earliest symptoms were glossy throat, fever and lassitude; they were given massive blood transfusions, and antibiotics. They were not however given ACTH or cortisone.

Dr. Goldman said that in all illnesses such as pernicious anemia, agranulocytosis, and so on, blood transfusions suppress bone marrow activity. The condition apparently occurs only in patients who are getting at least 400 milligrams a day. He does not do blood counts, although he does watch his patients closely during the first six weeks, particularly the women, and all other patients on fairly large doses.

Knowledge of Effects Developing

A question was asked about the period of sleepiness which follows with both chlorpromazine and reserpine. Dr. Goldman said he considered this of no importance. He thinks it will still be a number of years before we have learned the very best procedure for handling patients after drug treatment. We are, however, in the process of developing this knowledge. He spoke of the other side effects to be expected from the use of the new drugs, of which Parkinsonism was the most serious. If this was carefully managed, however, it should not be too difficult. Reserpine can produce certain cardiovascular effects, but any reasonably competent clinician can handle these by adjusting dosages and giving other drugs. The agranulocytosis from chlorpromazine was found predominantly in middle-aged women; they have found no cases among chil-

dren or patients over seventy. This latter might be because old people have been given lesser doses of this fairly potent drug. They had been given up to 900 milligrams a day of Frenquel, however, with no appreciable side effects.

Dr. Hafron asked whether chlorpromazine could be put up in spanules for the smaller maintenance doses of 50 to 150 milligrams a day. This would help solve the problem of dispensing the medication b.i.d. or t.i.d. Dr. Goldman said he thought that the biggest dose to be put out in a spanule would be 100 milligrams. It was not yet available, he thought, but was under consideration.

The fact that many patients threw away their pills instead of swallowing them was mentioned by several discussants. This would introduce a variable into the results, if you could not be sure who got the medication. It was said that this difficulty could be partially solved by enthusiastic and conscientious ward personnel. Dr. Hafron said that possibly others beside himself had had the unhappy experience of having a patient, after the ward personnel had reported medication actually placed in his mouth, accumulate an almost lethal dose of a barbiturate and later take it at one gulp.

He also raised the question of the selection of patients, asking if we had yet reached the stage of being able to apply reliable criteria. He recalled that initially metrazol had been used only for schizophrenics, but later it developed that the indications were better in a depression than in schizophrenia. Many hospital physicians have had the experience of being pressured by relatives to use chlorpromazine where it did not seem to be indicated. To hold off relatives, he would say "If you will buy it, we will give it," being sure that they would not do so. But they always obtained the money somehow, and so it was used on passive, withdrawn schizophrenics where presumably it was not indicated. Some rather startling results occurred.

The drug is certainly not a panacea for all mental illness, said Dr. Pollack. Our expectations as to its effects vary according to the type of patient. Many physicians in private practice say these drugs are just a flash

in the pan, yet when they see the results obtained in a hospital with carefully selected patients, they want to use them indiscriminately on their own patients.

Dr. Lieberman said that we should be cautious in ascribing all dramatic improvements to the use of the tranquilizing drugs alone. Many unknown factors, such as changes in attitude on the part of staff members, undoubtedly enter in. At Agnews State Hospital a control group was established and nobody treating the patients knew who the controls were. The study showed great improvement in both groups—those who had re-



This plant, *Rauwolfia serpentina*, from the Himalayas of ancient India for epilepsy, insanity, and a variety of other ailments. Reserpine was isolated from the bark of this smooth-leaved shrub which bears small pink flowers.

ceived chlorpromazine and those who had received placebos. After the experiment was completed various clinicians, psychiatrists and psychologists endeavored to name those patients who had been on chlorpromazine. They were 58% right.

In Illinois a small double-blind study was also carried out on a small group of patients. The final conclusions cannot yet be drawn, but tentative conclusions indicate that it is quite possible to reduce the amount of chlorpromazine and reserpine and still obtain the same therapeutic results. The use of tranquilizing drugs for so many patients in so many hos-

pitals leads to the need for better teaching of the basic therapeutic techniques so that everybody can participate in the program, whether with a simple or an advanced skill. The enthusiasm of the employees should be utilized and channelled into activities which are helpful to the patients. Not only the relatives get hopeful for the patients' recovery (and incidentally more people are coming into the hospital, said Dr. Pollack, because they are beginning to think of it as a medical instead of a custodial institution), but certainly the nurses and attendants will feel that they are accomplishing something. They are therapists—they are helping the patient. They are not just cleaning, feeding and so on. Miss Ogilvie said that it pointed up the need for more qualified nurses in the hospitals, if only because of the need for more in-service education for the non-professional people who are working on the wards where the new drugs are being given. This can only be done as it should be done under good supervision by nurses working in the team approach and with consistent teaching of the non-professional personnel. Neither nurses nor attendants must be turned into pill pushers who do nothing else but give medicine to the patients. These nurses can watch for the complications, especially acute appendicitis, bowel obstruction and so on, which may be masked by the use of the drugs. Some patients on chlorpromazine become very constipated. There are more fecal impactions than before; in one case, the bowel was perforated by giving an enema. This was not attributable directly to the drug, of course, but in a sense it was almost a direct result of its use. We must again improve our medical knowledge, from the doctors and nurses down to the attendants.

Dr. Hasselbacher raised the question of chronic schizophrenics who had not held or maintained their improvement, and relapsed very quickly when taken off the drug. What about sending such patients home? Should they go with prescriptions to take the drug at home under the supervision of a clinic or their local physician, or should we endeavor to have patients drug-free by the time they leave the hospital? If we know a patient to be assaultive without the medication, but fairly docile and acceptable at home

under the medication, we must ask if he will continue to take it once he leaves the hospital.

Dr. Goldman said he thought the best answer was to continue treatment indefinitely just as you would continue insulin for a diabetic or Vitamin B¹² or liver extract for pernicious anemia, anti-convulsants in epilepsy and so on. In sending patients home we should be careful to try to develop judgment as to how soon it is safe to discontinue and how much medication must be continued.

Outpatient Treatment

Dr. Pollack said that at present they have 250 patients being treated with drugs outside the hospital, most of whom had been inpatients. Some had applied for voluntary admission, but it was felt they could be better treated at home. Others were patients who had not been treated with the drugs in the hospital, but who after discharge had had symptoms of relapse and so were put on the drug. His normal return rate from convalescent care is between 30 and 35% without treatment; of the treated group, only 5% of the first 150 that he analyzed had returned. Only 7% of another group of 250 have returned and this shows that there is a marked advantage in the treatment of patients after they leave. These patients may have to be treated forever, but this is a small price to pay for keeping them well and out of the hospital.

Dr. O'Donnell said it was extraordinary how one was always asked the question "How many patients are you getting out of the hospital?" Yet we all know that in all types of disease there are cases which will remain chronic in spite of everything we do. All the stress is put on how many patients may go out and very little consideration is given to how much comfort can be given to those who will never get well; the budget people never seem to be interested in whether or not the new drugs or the shock treatment will make life more pleasant and more livable for those patients who will have to remain in the hospital for the rest of their days.

Dr. Gysin said that every possible means should be used to get money for this new program; it would even be justifiable to stop other valuable programs and projects if you must to get



...the Himalayan foothills, was used in a variety of other diseases. In 1952 the...apering, snake-like roots of this small, ...pink flowers.

over the hump, so that every patient who could benefit can continue to receive medication.

Dr. Goldman agreed that our enthusiasm was based on pretty objective concepts. He believes that the new drugs are as big or even a bigger advance than insulin or electric shock. Yet those people who were horrified at electroshock are now unwilling to give it up to use drugs!

Dr. Adams asked whether, since the general feeling is that there is ultimately going to be a reduction in hospital population, anyone has attempted to establish a base line from which the law of diminishing returns might operate to our disadvantage? In one sense, he said, we are talking out of both sides of our mouth. We want more money; we want more capital outlay; we want more staff—but we expect a reduced population.

Have we any experience to enable us to say how far we can hope to reduce the hospital population? Dr. Goldman said that answering that question would be essentially pitting human beings versus dollars. It is not too much to spend millions of dollars to save human lives and to make human lives more effective, when we already spend billions for the potential capacity to kill. However, the practical answer is something like this: for five or ten years we are not going to change the fundamental quantitative aspects of the problem much, because it will take that long to develop enough clinical understanding and experience of the usefulness and the nature of these drugs and their reactions and all the things that go with them. This means that we will need rehabilitation, social service and activities in increased measure—everything we know of that can be added to the drugs to make them effective. We do not know what will happen when we are no longer treating psychotics with the residual of ten, fifteen or twenty years hospitalization. Nor has any legislator, any Governor or anyone else a right to ask this question, because the real problem is that we do not have the right to put dollars against human beings.

Dr. Bush pointed out that the main theme of this Institute was the freedom of patients. Certainly the use of these drugs has enhanced this program of freedom. We need both

drugs and personnel to get patients out of the hospital more quickly; consequently, while the cost per day may increase, the cost per patient illness will decrease. This is certainly true with the use of the drugs. Therefore, more money for personnel and more money for drugs will ultimately result in a saving to the taxpayer.

Architectural Plans Affected

There are some practical aspects regarding the architectural designs of new buildings which will certainly result from the use of these drugs, and of other drugs not yet discovered, if they continue to prove out as we think they will, he continued. There will be need for fewer detention rooms—indeed the need for any at all may be practically eliminated. There will be need for more activity rooms, more recreational and occupational therapy facilities; there will be need for less areas for electroshock and for more outpatient and day care facilities.

Most people believe that psychotherapy must be continued with the use of the tranquilizing drugs, said Dr. Campbell. However, with a very limited staff, he sends out a great number of patients who have not had any opportunity to experience psychotherapy and they seem to get along all right. Dr. Goldman agreed that it was difficult to evaluate psychotherapy, or any other kind of readaptation work, which may be a better general term. Patients who have been admitted only recently have not lost all the elements of social and industrial adaptation. Once they get well they can quickly pick up the threads again. The hole that was left in society by extracting them and putting them into the hospital has not yet been overgrown by weeds or filled in. But when patients have been in the hospital for five, ten or fifteen years, and yet reach the point where they can be rehabilitated, it is going to take a great deal of activity by a great many people to make the patient himself capable of readapting usefully to society.

Psychotherapy is not the formal matter of what happens between the doctor and patient in a face to face relationship; it includes much that is indefinable and will be required more by those who have lost their relation-

ship to society than by those whose illness is of more recent origin. With such long term patients, we must first treat the illness and then rehabilitate the patient. That is the technique which is now in the process of development.

Dr. Goldman called upon Mr. Mike Gorman to speak briefly on the question of the budget in relation to the new drugs.

Mr. Gorman said it wasn't difficult to go to a Legislature which was already cognizant of the public pressure for these new drugs. They would certainly ask "How many people will you get out? Will you reduce your patient population? Can you cut your capital construction?" These questions were academic and fairly non-psychiatric.

What is needed is a real, solid, statistical and financial evaluation, instead of the usual testimonial. It is right and incumbent on a public body which is spending public money to ask these questions, and they have a right to clear answers, not obfuscations and controversies. They are not simple questions to answer. We cannot say tomorrow that some such answers can be given. But we must try to establish norms and standards, to show that we realize our responsibility to the taxpayer. We cannot make false promises. We cannot say that we will reduce our population by one thousand or some such figure. But we can say that we hope to do this within five or ten years, and that here is our broad experience so far to support these hopes.

This year we have managed to persuade the Senate to set up a special chemotherapeutic panel through the National Institute of Mental Health. This panel is to select ten or twelve of the larger hospitals and establish controls and standards—tough, statistical and biostatistical standards. This work is to go on for a year or two, and will be in a sense an epidemiological study in depth, rather like the studies of Malzberg in New York State—the kind of thing that you can look at and not groan after the first two pages. Since 96% of our burden is a tax one, and we have to meet annually with budget directors, those people have a right to be a little surly if we cannot give them the figures they justly request.

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CHILD PSYCHIATRY: Community Aspects

Chairman: G. Wilse Robinson Jr., M.D., Mo.

Discussion Leader: Exie E. Welsch, M.D., N. Y.

Presentation:

Out of 1280 out-patient psychiatric clinics in the country, 294 or nearly 23% of them are connected with state hospitals. In discussing out-patient clinics which see children, we should keep in mind the question of the usefulness this community facility has to the state hospital. How is the clinic helpful to the hospital and what problems does it raise?

A community child psychiatric clinic is responsible for giving service to disturbed children in the community, and secondly for utilizing all the resources in the community to help this child to healthy growth and development. From a service standpoint, there are four generally accepted areas of service: a diagnostic service which carries out a psychiatric study to determine both the nature of the child's problems and their etiology; the development of a treatment plan for the child, which may include treatment within the clinic for the child and his parents, as well as the use of other resources, if indicated, such as the school, the existing recreational and social service agencies and the hospitals; a consultation service to the community so that people like teachers, judges, nurses, social workers, and physicians can come for consultation regarding individual children; and finally mental health education to community groups such as government agencies and legislative bodies in the locality.

A child psychiatric clinic may also offer training for other personnel and may have research projects which it is fostering.

Responsibilities of Clinics & Hospital

There are many practical questions relating to any children's psychiatric clinic—staffing, administration responsibility, number of clinic teams per

hundred thousand population and so on.

If, however, this clinic takes the responsibility for a diagnostic evaluation and the development of a treatment plan, what are the mutual responsibilities of the clinic and the mental hospital to ensure that referrals to the hospital are appropriate? Such a referral means good use of mental hospital resources from the standpoint of the community and is an important function.

Where do the clinical responsibilities lie once it has been decided that hospitalization is required? Who works with the child and the parents during the waiting period? What kind of service should be provided for the family during this period?

During the child's hospitalization, what are the hospital's responsibilities for the continuing supportive help of the parents? How much of this rests with the hospital doctor and the hospital social worker? How much of it should and could be a coordinated effort with the community clinic?

Preparation for Discharge

When the child is ready for discharge what preparations can be made by the hospital to prepare the family and the community for his return? The child is going back to school, to his church group, his recreational group, his friends. Is this preparation solely the hospital's responsibility? Or can it be done in collaboration with all community resources?

Then during the third period, while the child is convalescent, who has the responsibility for his periodic psychiatric evaluation and who works with the parents? How do you bring in the other community resources to integrate the child back into his school, his church group and his friends?

Discussion:

Participants: J. O. Cromwell, M.D., Idaho; Robert S. Garber, M.D., N. J.; R. A. Jensen, M.D., Minn.; Maurice W. Laufer, M.D., R. I.; Harold L. McPheeters, M.D., Ky.; Donald F. Moore, M.D., Ind.; Norman C. Morgan, M.D., Pa.; G. W. O'Brien, M.D., Calif.; Elsie Ogilvie, R.N., D. C.; Hon. Harry Shapiro, Pa.; Mrs. R. R. Tamargo, N. Y.; Mesrop A. Tarumianz, M.D., Del.; Mrs. Julia Thomas, D. C.; Jack Wolford, M.D., Pa.

Dr. Tarumianz opened the discussion by saying that after operating a Mental Hygiene Clinic with a full-time staff of psychiatrists, psychologists and social workers for a number of years, he felt that merely having a clinic to treat children and parents once or twice a week was inadequate. Facilities were needed for the in-patient care of children and so the Governor Bacon Health Center for maladjusted, pre-psychotic and early psychotic children was established. The Health Center does not take delinquent, feeble-minded or defective children but the Mental Health Clinic examines, diagnoses and recommends treatment for children who come before the Family Court and before juvenile courts. Recently, a city community child guidance clinic was added to the resources available in Delaware.

Dr. Jensen of Minnesota mentioned the function of the child clinic in defining the unmet needs of children in the community—for instance, the child with a learning disability. Clinics throughout the country have been instrumental in helping to define this need, which is often the result of a serious emotional disorder in the child. Then, too, the clinic helps shape community attitudes toward the problems of deviant behavior.

Whereas in the past the community

clinic has been predominantly identified with other than medical resources or agencies, the increasing trend toward aligning the guidance clinic with child psychiatry and with the psychiatric hospitals has many advantages. Close identification with, or having the clinic within the framework of the hospital itself increases the effectiveness of diagnosis, because physical studies are of the utmost importance if one is to understand the child's problems.

Once, however, a diagnostic center for children has been established, it is necessary to face the medical responsibility for the therapeutic measures which may be required, said Dr. Welsch. This responsibility, however, is not unilateral. Children are the responsibility not only of the hospital, the clinic and the community as a whole, but also of the public, private or parochial schools.

In Delaware, said Dr. Tarumian, the school system has a Department of Child Guidance and Mental Health Education. It is the responsibility of a teacher to notify this department if a child seems to need attention. The department then makes a preliminary examination and gives a tentative diagnosis, and the child and the parents are referred as necessary. If such a Mental Hygiene Clinic plays only the role of diagnostician, then it is valueless.

Community Personnel Resources

The Public Health Nurse, said another participant, can play a very important part both in case finding and during the interim period between diagnosis and treatment. Moreover, since in educating nurses in a psychiatric hospital there is so little emphasis placed on community work, the hospital clinic can play an important part in educating student nurses, and for that matter affiliate graduate nurses, in the community aspects of psychiatry.

Another individual who can serve a valuable role between clinic and community is the school psychologist. He should have closer administrative ties with the mental health clinic, particularly the child guidance clinic. We could do a better job in finding upset, disturbed children and a better job of community work if the psychologist's attachment was primarily

to the clinics with consultant work in the schools, rather than to the Education Department where he gets lost in psychometrics and has very little opportunity to do much mental health work, said Dr. McPheeters.

There is a heavy responsibility on the staff of the clinic itself to foster and develop rich and useful communication with other resources in the community. If it does not do so, then responsible people in the community should confer with it about community needs, and strengthen the relationship. The clinic that tries to integrate itself into the community, rather than work in an ivory tower is the group which can act as a genuine resource for the community so that a teacher or a parent can call and say "We are troubled about this youngster. What can we do about him?"

Disposition of Mentally Ill Child

Mrs. Tamargo, a member of a mental hygiene group, objected that while most teachers meant well, many of them were alarmists, who, if a child was caught daydreaming, too quickly would say he was mentally sick and refer him to a clinic. Dr. Welsch replied that this amounts to the teacher trying to assuage her own anxiety by saying that a certain child needs psychiatric help or treatment. This was one excellent reason to develop a good consultative relationship between the clinic and others in the community.

The question was raised about what to do with a child whose difficulties were too severe for the clinic to handle, and where some separation from the family and the community might promote rehabilitation. Dr. Jensen said that he would be most reluctant in most cases to have a child transferred directly to a mental hospital unless he displayed the most obvious signs of psychotic behavior. At his hospital a number of children have been admitted who, after a short period, have been found not to be psychotic and not to be so seriously disturbed as was thought at first. Some thought should be given to effecting some kind of intermediate stage between admission to a state hospital and the preliminary study in the clinic.

In Pennsylvania, Mr. Shapiro said,

they are attempting to meet that problem by the establishment of classification centers. In Philadelphia, representatives of the Board of Education, of the Department of Health and Welfare and of the city itself are joining together to deal with this problem on a diagnostic and a therapeutic basis. When the child's needs are determined he will then be treated by the classification center, a diagnostic treatment center where he can best receive the treatment he needs. As many diagnostic treatment centers as are needed will be established, so that the child will be kept out of a large institution if possible.

One of the worst defects of community clinics as they exist today is that personnel are not properly trained to operate a child guidance diagnostic and treatment center, said another participant. There is no use in assigning residents in training to a clinic unless they meet all the necessary requirements and unless they are assigned for long enough to make a sizable contribution and learn something at the same time. Even the average psychiatrist does not necessarily do a good job in the education of lay groups, which is a large part of a clinic's responsibilities.

But Dr. O'Brien said that as a recent resident, he had worked in a community clinic which was a part of Stockton (Calif.) State Hospital, screening patients, seeing patients in treatment as part of the hospital program and so on. This training helped him understand the problems of the community as a whole, as well as acquainting him with the community agencies. These things he would not have learned without his clinic experience. Also it was good for the hospital itself, as the community became much more aware of the role of the hospital as a part of the community rather than as a separate body aside from the rest of the community.

Dr. Welsch asked whether hospital people saw the clinics as being of use to children on the verge of being discharged, or who were still on convalescent status. Dr. Cromwell described an unusual plan of organization which dealt with this particular problem. Although he has no actual child psychiatrists he has two experienced psychiatrists on the hos-

pital staff who have worked for many years with children, also a psychologist very skilled in children's work. Whenever children come as inpatients or outpatients, they are assigned to this group for evaluation. Thus they serve as a screening team, admitting a child if necessary, but always carrying either adults or children as outpatients if it can possibly be done. Treatment is provided on either basis, however, and provides for individual therapy, group psychotherapy, play therapy and activities. When the child is ready for discharge the hospital has a useful working arrangement with the Social Work Division of the Department of Public Assistance, the Public Health Nurse and others for

follow-up care if necessary. Dr. Welsch said this was a far better plan than simply handling admissions and discharges of children on the basis of who happened to be on duty that day.

Dr. Moore said that in Indiana a mental hygiene class was started for the teachers—it was essentially a case work study group. These teachers spend so much time with children that they afford one of the most important "screening groups" in the community. After some classes, these teachers began to feel more confident because they knew what the community resources were, and how best they could refer a child with problems. It is not necessary to train teachers to be therapists, but you can let them know

that there are resources, and how they can use them. They feel much more comfortable, and much more assured, and the children they work with reflect this greater security.

Dr. Welsch ended the discussion by saying there was a great need for more specialists in child psychiatry, and that there was also need to incorporate into all residency training a good healthy dose of experience with children with different problems in different settings. Among administrative problems discussed, the most important one was that a definite team should take responsibility for working with children in a hospital or in a clinic.



This little girl's personal problems were too overwhelming to allow her to enjoy a class-room visit to the Zoo. Teachers are one of the most important screening groups in the community and need information about psychiatric resources and how to use them. (None of the children in this picture have ever been patients in a psychiatric hospital or clinic.)

CHILD PSYCHIATRY: Hospital Aspects

Chairman: G. Wilse Robinson, Jr., M.D., Mo.

Discussion Leader: Fritz Redl, Ph. D., Maryland

Presentation:

I would like to focus our discussion around certain areas which are challenges and problems in a psychiatric service for children.

First we must remember that child patients in a psychiatric hospital are still kids. As a rule the hospital was originally designed for some other purpose, and you know what it means to put any kids into something that wasn't designed for them originally.

Next, children have a wide variety of tasks still unfinished and still to fulfill, as contrasted to the supposedly fully developed adults. You can never forget that some of the educational and developmental tasks of growth still need to be protected; your service is designed to give them psychiatric help but you must also give them the vitamins of educational stimulation, and this is a terribly complex problem. For instance you must consider age range and compatibility; styles of activity and designs of layout are not equally suitable say for adolescents and three-year olds.

Next comes the problem of activities. Even if all the children do not always show hyper-aggressiveness, temper tantrums, extreme restlessness and destructiveness, some of these will show up during treatment. Moreover even normal children need a much higher rate of activity-program exposure than do adults.

How then can you expose these children to all varieties of activity, from quiet games to active participation? In spite of the fact that you are treating them for psychosis you cannot hope that a specialist looking at them for half an hour every other day can take care of any but the specific ther-

apy problems. And they need things around them to hang on to, to manipulate and to construct, just as do ordinary children in school.

Then there is the learning process. What happens to their cognitive functions while they are in hospital? Even though the child's major disturbances may be emotional, most of such children are also afflicted with a wide variety of learning disturbances. Even if they are not, you cannot stop for a lengthy period that part of their lives which the school would take care of. You must devise means by which intellectual hunger can be fed and learning apathy counteracted; all the children must continue to be exposed to learning potentials.

Relationship Needs

There is the importance, too, of individual adult relationships. Even sick children need some peculiar relationship to individual adults. How can we select from a large number of people with whom the children will be in touch the kind of adult roles and relationships they need?

Most of the children are badly confused, yet we expose them to an administrative setting and to a large number of strange people. It takes a good paranoid delinquent to point out to you where the unexplored complications exist in your structure! This raises the question of how to devise a design so consistent in structure that even confused children can grasp the basic meaning of the role distribution. There must be a concerted effort to help them do this.

Next comes consideration of the fact that these children came from and will go back to their own parents

or guardians so that your contact with the existing parent figures is a terrific responsibility. The hospital has an obligation to deal with the parents and their feelings, to help the parents and the foster parents, or whoever later on fulfills that role for the child, to pick up where restored abilities of making relationships have been produced. You have therefore quite an out-patient function with the marginal personnel in the child's life, whether this was considered in your budget or not.

Child patients will produce a lot of behavior which needs to be limited. So we have the task of finding clear-cut criteria for setting limits—where these limits should be and how we should set them. This task is as important as it is in the education of normal children. How to set these limits wisely and hygienically is a problem for all your staff. What forms of limitation of extreme behavior can be devised which are not dangerous and are even supportive?

The Child As a Patient

Now let us reverse the original statement, and say that kids in a psychiatric hospital are also patients. The hospital is not just an amusement park or a punitive institution. It is a place to give well focused treatment to definite forms of disturbance; it means that certain parts of the child's personality are so disturbed that he needs hospitalization.

The fact that these children are patients carries a number of implications foreign to the educator of the normal child; there are definite needs which must be built into the setting in which we treat them. Since these

children have certain diseases, they are different from normal children; the same activities that normal children would love, these children cannot take. Their taste buds for activities may be so underdeveloped that a normal neighborhood program would be poison for them and would produce one over-excited temper-tantrum after another.

Group Composition Important

These needs must not only be known to the psychiatrists, but must be considered in the whole design of the children's ward. Group composition, while it cannot always be chosen, is important. Who lives with whom in a sub-group or an activity group is vital; you must know which pathology will travel well with which other pathology, and which may be poisonous to one another. The assessment of such factors determines who should live in the same dormitory, work in the same classes and play in the same group.

Still considering the child in his patient role, we must realize that improvement within an institutional setting may not mean the same thing as real improvement. We need more research to determine when we may risk exposure to the non-hospital climate and be reasonably safe in assuming that adjustments can be made.

Discussion:

Participants: Richard E. Bartman, M.D., Kans.; Daniel Blain, M.D., D. C.; Howard T. Fiedler, M.D., Pa.; Reynold A. Jensen, M.D., Minn.; Granville L. Jones, M.D., Va.; Simon Kwalwasser, M.D., N. Y.; Mrs. Eleanor A. Loija, Ky.; Georges H. Lussier, M.D., N. J.; Theo K. Miller, M.D., Calif.; Mrs. R. R. Tamargo, N. Y.; Mesrop A. Tarumianz, M.D., Del.; Mr. Wilbur Taylor, D. C.; Isaac N. Wolfson, M.D., N. Y.

Dr. Bartman, from Parsons Training School in Kansas, opened the discussion by saying that although they operate a school for the mentally deficient, they found that in order to function properly they could best work by functioning as a psychiatric hospital. Their children are high-grade defectives and are not multi-handicapped. They were themselves struggling with all the problems Dr. Redl had listed. Their basic prob-

lem was defining what the needs of the institutionalized child really were, and communicating this information to the community and the state government system.

It was generally agreed that the planning of psychiatric services for children was of increasing urgency, but that before this could be done intelligently, many questions must be answered. What group of children is to be served by this facility? What is a child? What age group do we mean? How can we set up a system of evaluation to ensure proper placement of children—psychotics, pre-psychotics, mentally deficient, behavior problems and so on? Should a child be committed to a state hospital or is there a better way? Where should this facility be placed—as an integral part of an existing hospital or as a separate unit? If as a separate unit, where should it be placed in relation to other state units, to large medical centers, or a medical school? What kind of personnel will be required and how many will be needed to provide an over-all program that will not only meet the child's therapeutic needs but all the other needs he will have during his hospital life?

Factors in Design

Mr. Taylor said that the matter of designing a psychiatric hospital for children is something that is going to require a great deal of thought and attention. Many children's units are located on the upper floors of large psychiatric hospitals, and the ground floor is used for administrative offices. It is difficult to handle even normal children in an apartment house, and this amounts to the same thing, added another participant.

The most important thing is for the architect to know exactly the function, size and location of the hospital, continued Mr. Taylor, and everything you are going to do in it. Form follows function, he added, and when it comes to children's units, the architect should be informed about all aspects of the specialized program.

Dr. Kwalwasser discussed staff ratios, saying that at Hillside Hospital they had twenty-six people taking care of nine girls and yet they still felt short of help. The patients are psychotic girls, from fourteen to six-

teen. It is more or less a research unit. Not only is each girl treated individually, but each of the people working in the unit—even the maids and the stenographers, sit in every day at a staff team conference, so that everyone who has any contact with any of the girls is a part of that team. Although this staff ratio sounds enormous, they also carry out a program for the parents. One of the criteria for admission was that parents should also be treated. A rehabilitation and follow-up outpatient service has been established to take care of the girl after she leaves the hospital.

Mrs. Tamargo made the point that in the average home there is the father, the mother and frequently a full-time and a part-time maid, all of whom help to take care of one or two children.

Dr. Redl said he knew of a situation where it took six people to give a patient insulin shock. Since you must have six people or you can't complete the treatment, you accept this as a clinical reality; the psychological realities are just as unrelenting as the physical ones. When mother and father and school teacher have failed, why pretend that the hospital can do the job with insufficient staff?

Dr. Tarumianz said that if you divided the twenty-six employees by three shifts, and took into consideration vacations and sick leave, it was not as expensive as it sounded. At the Governor Bacon center he has 250 employees for about 300 patients, and that is not a private organization.

Determining Staff Roles

Before there can be any realistic discussion about program there must be discussion of staff, staff roles, staff training and staff turnover. Disturbed youngsters are inordinately sensitive to moods and dispositions of others. Therefore people who really know how to look after children must be sought. This cannot be judged entirely by diplomas.

Dr. Jones asked how you could provide parent substitutes for children in an institution. One school of thought said that you should use a cottage system staffed by a kind and loving couple who would be foster parents, so to speak, for fifteen to thirty children.



"I don't know that I would want anyone who had such neurotic needs to do a job like that!" he said.

The alternative was to fit staff in to the eight-hour day, forty-hour week system and have a rotation of people. But this did not leave much time for personnel to form the needed emotional ties so that the child had a parent surrogate always available.

Dr. Tarumianz said that he had found the cottage system, with eight to ten children in each worked well. The house mother worked only a forty-hour week, but she worked so many days and then went off for so many days. If a husband and wife were working, the same arrangement applied. If you also have a chief counsellor and an assistant and many associates who are able to train these people, it works well. They are carefully educated to establish themselves as fathers and mothers.

However, it was said, not all personnel properly fall into the category of parent surrogates. Not everybody in the institution is supposed to be a parent substitute. Nor are they in the community. A teacher is not a parent substitute. At home the children have people in their lives who perform a variety of functions. The children, especially the older adolescent, may need somebody in

the function of a child-minded group leader. Or certain parts of the parent relationship may be supplied in the institution, while other parts of it may still remain intact with the remaining parents on the other side, and may be cultivated. In other words we do not always have to substitute for the whole relationship.

Another personnel problem is that of turnover. Rapid turnover of staff is very upsetting to children. They begin to make some sort of relationship and suddenly the person goes. Anna Freud found this out during the war when she was working with displaced children.

Specific Training a Solution

Dr. Redl said that training people for the specific functions and motivating them to work within residential children's units is probably the long range answer to the turnover in personnel. If we can continue to increase the number of parents' clinics, and increase the challenge to use residential therapy, perhaps we can also make a concerted effort towards motivating the right kind of people to get into this area, and help them get the kind of training they will really need. What can we do to make people wish to enter this field with more awareness of the problems of children, so

Not all staff members working with children have to be parent-substitutes. Children may need somebody in the function of a child-minded group leader. Staff turnover, however, can be damaging, but if a good team can be worked up and kept, perhaps the question of parent substitutes is not so important.

that you do not have to take people from other disciplines and give them on-the-job training before you can begin?

Dr. Wolfson wondered if we should try to create an entirely artificial atmosphere in a children's unit? After all, he said, we are teaching them to live. None of us are perfect. We have our bad days and our good days. Perhaps we should accept these realities rather than try to create artificial means of removing them which is nearly impossible.

In his school he has 3100 children and 400 employees around the clock. Therapy is primitive. Most attendants were untrained when they came. Some of the children have behavior problems, others are neurotic and disturbed and rejected by their parents. Many have been in seven or eight foster homes before landing in the hospital as rather sick children. Yet it is amazing to see how these children do grow up, get out into the community and make a pretty good adjustment. A small follow-up eight years after discharge has showed amazingly good adjustments. In our research work therefore, we should consider what are the innate potentialities and thresholds of the child.

Dr. Redl agreed that we should not get over-fancy, since children do have

to learn to meet reality. As researchers we should perhaps distinguish between what is absolutely essential for research and what we need not do if we are working in treatment and not research. Yet, in a surgical operation we certainly want bacteria kept out, although later on the patient will be able to fight them without getting sick. Some of our children in the process of treatment have a higher vulnerability. And our demands for psychological hygiene and programming is of that nature, though of course nothing is easier for clinically minded people than to retain an overprotective and sickness-cultivating atmosphere, forgetting that after a certain point the individual must be exposed to reasonable risks and challenges.

Children in Adult Wards

Mrs. Loiija raised the question of caring for sick children in adult wards. Her experience was that the children seemed to improve especially in their ability to get along with people in the hospital. One young girl who had been in the hospital for ten years—since she was six—was transferred to an adult ward. She deteriorated and had to have maintenance electric shock; everyone got concerned about her. Everybody in the hospital made plans and tried to understand what her needs were. At that time she was on the female disturbed ward. Next she was transferred to a privileged ward of old ladies, and was the darling of the group. She was put on full privileges and had a job in the laundry. She took part in the dances and other recreation. Next they planned for her to visit a family on weekends, and before very long, she will probably be out in the community all the time. All of this was done without special facilities.

Dr. Fiedler however, thought that it was a dangerous policy to have children on adult wards. They tease the adults, producing in them many of their own aggressive attitudes. Alternatively both nurses and patients make pets of the children and the personnel look after them at the expense of other patients. He thought that children's units should be removed from a state hospital setting and set up as single units in an urban area near medical schools and training

centers so that adequate residential and supervisory staff was available in addition to ordinary personnel.

Dr. Lussier thought that such a unit should be small. Children need a personal touch that cannot be produced in an institution taking hundreds of patients. Psychiatry today placed childhood from five to twelve years old, and this would be a proper age range for such a unit.

At the Brisbane School, they carried both psychotics and behavior problems, but found this unsatisfactory. The little autistic children need so much attention that the behavior problems were forgotten; these children felt rejected and of course acted out.

If you have a children's unit, and have no adults to worry about then your program is going to be entirely geared to the children.

Dr. Redl summed up by saying that while we should not be too "either/or" we must remember that children are different in size, in needs, in types of pathology and program needs, not only from adults, but from one another, depending on age groups and pathologies. We do need far more communication before we can get together and compare notes constructively. More information is needed on specific details. The controversy about children on adult wards showed that in one situation, the children actually benefited, while another speaker showed that sometimes, if youngsters are simply thrown into a large unstructured situation or an adult ward, this could be quite wrong. What are the criteria we should use to decide this matter?

Clear Communication & Interpretation

An important task is to look to other people for better and more effective community interpretation, not only about the function of the children's units within a psychiatric hospital, but also to "decontaminate" a children's service, so that you don't hesitate to send a child there because it is a mental hospital. There must be a clearer specific picture of the types of facilities we should try to develop and a clearer interpretation to the public. Much better communication between ourselves and the community is needed to carry out these tasks.

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BARRIERS BETWEEN NURSE AND PATIENT

Discussion Leader: Miss Mary M. Redmond, R.N.

Presentation:

There are many new discoveries in the field of psychiatry which are reflected in changes in nursing techniques. The discussion this morning should bring out many helpful points which those present will want to try out when they return to their jobs. Perhaps some definite way may be found to answer the need for the nurse to be closer to the patient. We must take time to evaluate, discuss and find new ways of overcoming the barriers which keep the nurse from giving her best and the patient from getting what he needs from her. What are some of these barriers? What do we want most to do for the patients? What is the nature of the need the patient has for the nurse? What is interfering with the patient having this need satisfied?

In managing the administrative details necessary in good patient care, we should evaluate what is necessary and discard what is not. There are great differences in the educational backgrounds of psychiatric nurses, differences in the functions, differences in the job descriptions of the work. Do nursing routines and standards act as barriers?

Discussion:

Participants: *Ellen Andruzzi, R.N., Wash., D. C.; Joseph B. Bounds, M.D., Mo.; Esta Carini, R.N., N. Y.; Ian L. W. Clancey, M.D., Sask., Canada; Mary E. Corcoran, R.N., Pa.; Laura A. Davidson, R.N., Ohio; Eleanor Dawson, R.N., Ohio; Mr. John V. Gorton, N. Y.; Granville L. Jones, M.D., Va.; Eleanor A. Loija, R.N., Ky.; Clora I. Mattox, R.N., Va.; Norman Morgan,*

M.D., Pa.; Chaplain M. Nicholson, Okla.; G. W. O'Brien, M.D., Calif.; Elsie C. Ogilvie, R.N., Wash., D. C.; Leslie Osborn, M.D., Wis.; Lucy D. Ozarin, M.D., Wash., D. C.; Julia Thompson, R.N., Wash., D. C.; Wm. W. Thompson, M.D., Ore.; Evelyn White, R.N., Ky.

Miss Ogilvie said that much of the nurse's time is taken up with administrative problems, such as handling the patients' clothing, which might well be looked after by a clerk.

Miss Dawson said at her hospital there is such a ward clerk. She added that nurses, however, seem loath to lose their administrative duties, because they have never been told what their other function is. A positive description of the psychiatric nurse's duties and functions may be an answer.

Dr. Osborn said he felt that the doctor is the chief barrier between the nurse and the patient. The psychiatric nurse properly expects to be a team worker but she is handicapped without a clear outline of her function on that team. Physicians in responsible positions should set up programs utilizing the nurse and giving her wider scope to do what he, the physician, cannot. He has little or no opportunity to know the patient personally so must work through the nurse.

Sometimes barriers are more apparent than real, said Miss Corcoran. What are sometimes considered barriers are really attitudes. Nurses vary in what they like to do. Some like to do paper work. Others like to work with patients. We must get back to the concept of psychiatric nursing—the nurse with the patient. Every

patient should know a nurse to whom he can turn when he needs her. If the nurse is "too busy", we must find out why. A nurse who wants to be with patients will find a way.

Miss Redmond said that division of duties is necessary. Some of the administrative details, which do perhaps lead to better patient care, need to be evaluated.

Dr. Granville Jones (Chairman of the American Psychiatric Association Committee on Nursing) pointed out that there are many other people working on the wards who are not graduate nurses. There is no adequate description of functions. What is the nurse? What is the aide—the attendant—the clerk? Where do the housekeeper and the janitor come in? Until we have a clear definition of the functions of the nurse, we cannot solve some of these problems.

Supervision is a big problem. The nurse does have supervisory functions which do take her from the patient. The graduate nurse wants to be the supervisor. She can help other ward personnel in developing interpersonal relationships. A good supervising nurse spends time teaching ward personnel how to work with patients, by personal example, by teaching groups or by both.

An important aspect of psychiatric residencies is to teach young doctors to use other people who are eager and able to help. It is easier to do psychotherapy, for instance, than to train the nurse to do it.

Some nurses busy themselves with administrative details because they are afraid of their own neurotic needs. They must be taught to deal with these fears.



The concept of psychiatric nursing is "the nurse with the patient." Every patient should be able to turn to a nurse when he needs her. A nurse who wants to be with her patients will find a way.

Miss Lavonne Frey agreed that nurses are sometimes afraid to work with patients, afraid to break down the barriers. She cited a group of eager student nurses who questioned the doctor about the care of psychoneurotics. He had mentioned nothing about the relationships between patient and nurse. He told them that there is nothing the nurse can do for the patient. Sometimes the doctor assumes that he is the only one who can provide therapy for the patient; thus he cuts off the nurse from providing what she can. The nurse must feel that she can help the emotional needs of the patient, but she must operate within a medical framework. The doctor's goal in therapy is not always explained.

Dr. O'Brien said that when he was a resident, he set up a treatment team, working with nurses and attendants, on the acute treatment service. The nurses were supervisors and both nurses and aides worked with patients. Dr. O'Brien's role was as administrator and supervisor of the team. Regu-

lar discussions were held on patients' problems. Understanding their role and the patients' roles, the nurses were better able to work as part of a team. The program was worked out in detail so that each individual aide worked with a special group of patients, supervised by a nurse, under the direction of the doctor. The nurse was both supervisor and therapist. The weekly discussions of the patients' cases familiarized everyone with all of the patients. Such an approach, well-worked out, can satisfy the nurses' needs and break down barriers which are sometimes set by patients themselves.

The Nurse As an Administrator

Miss Loija spoke of the advisability of some administrative responsibility being taken over by non-professional workers thus leaving professionally trained nurses to do clinical work.

Dr. Jones said that since administration is the technique of getting a group of people to perform a given objective, nurses cannot avoid ad-

ministrative work. If someone else has the responsibility for the ward, we will find the nurse in a subordinate position.

Miss White said that in her hospital, the nurses' duties are defined, i.e. educational, clinical work or administrative, and the nurses find this raises their status. The aides are happier, too. Everyone has freedom within her own domain. It is not necessary to see three or four different people about some particular question.

Dr. Morgan said that when the physician gets to the administrative level, he soon finds out that he is doing clinical psychiatry but on a more complicated level—because those with whom he is working do not consider themselves patients! Nurses are the same in that when they are administrative nurses, they can use their psychiatric training in helping people who are going to work with patients.

Nurses were being left behind in training programs, he continued. Some aides know more about the latest advances than do the older nurses. It is necessary to develop a program of intraining of the psychiatric nurse who has not had any formal training.

Mr. Gorton asked that the role of supervisor be defined. Whom does she supervise? What is her responsibility? This is not clearly defined in the psychiatric field. The young nurse flounders when she does not get the support of the supervisor of nurses and/or the doctors; because she does not have a clear understanding of what her duties are, she falls back on the aides for help and support.

Dr. Bounds asked if the nursing profession actually supports the creation of barriers between nurses and patients? He felt that a philosophy which tends to create the nurse educator, the nurse supervisor, etc., and another group of people as aides to do the work on the wards, creates an insurmountable barrier. He would like to eliminate some of the many conferences which seem to create barriers between staff nurses and patients. He would like to have a nurse stay a staff nurse and not always want to go up the line to be a nurse administrator or a nurse educator. He would like nurses to let a secretary answer the phone and do the clerical work.

Chaplain Nicholson said that the

patients are the first to recognize barriers because of their keen perception. So does the family. In some types of organization various levels are necessary but not in the nursing service.

It may not be necessary to remove administrative responsibility from the nurses, Miss Redmond said, but it is necessary to remove administrative detail.

Many doctors are accustomed to work with nurses and to rely upon them in a general medical and surgical setting, declared Dr. Ozarin. Nurses must show doctors what they are capable of doing in a psychiatric setting where their professional judgment should also be heard.

There is not sufficient time given for student nurses to develop the psy-

chiatric approach. They do not acquire understanding of the mentally ill patient. Some nurses are basically afraid of these patients. They feel that they have the responsibility for taking care of their physical needs, but do not understand the therapeutic approach. They don't like to listen to patients' problems. They cannot project their own personalities to meet their patients' needs. After they are trained on a particular ward, they have marked resistance to working on other wards. There is a large turnover of young nurses. This instability reflects back on the patients.

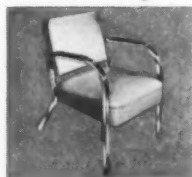
Specialization a Barrier?

Miss Carini said that she feels that an attempt to make psychiatric nursing a separate specialty may be the greatest barrier. The needs of the patients on all services are the same. They are human beings and they need care. It is a matter of personal philosophy.

Nursing, said another participant, has not produced enough qualified people; people who are not qualified have therefore been put into positions of responsibility. Nor is there provision for parallel advancement. A nurse must rise to another job level to receive more money, rather than receiving more money for doing a better job in the same category.

Miss Davidson spoke of the lack of understanding between nurses and aides. In her own experience, it could often be seen that no one bothered to tell anyone else why certain things were done. A good nurse spends most of her time out on the wards and she can discuss the patients with the aides and doctors to help them to understand the patients. There would be better understanding if the nurse could interpret and coordinate; all the workers on the ward could take part in treatment if she channeled efforts in this way.

Miss Redmond spoke of a group of student nurses who interviewed patients as to the patients' needs. The patients outlined what they wanted the nurse to BE, not what she should do. That is what had been done by this group. She hoped it would cause participants to re-examine their methods and attitudes in order to improve the nursing service.



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METAL FURNITURE SINCE '97

Procurement of Supplies For the Patient

Chairman: Mr. R. Bruce Dunlap, Penna.

Discussion Leader: Mr. A. C. Yopp, Kansas

Presentation:

Most items furnished in a mental hospital are intimately and closely related to patient care. As treatment concepts change, it is important that supplies for patients change to meet these new concepts. Procurement procedures should operate for the benefit of the patient and not as unnecessarily restrictive practices which may actually prevent the acquisition of needed supplies and equipment.

Since most hospitals are tax-supported, procedures must be set up in accordance with purchasing laws and regulations, with respect to competitive bidding, quantity purchases and scheduled buying.

Some administrators like to utilize the knowledge and skills of various staff members in formulating purchasing policies, because the people who are responsible for the care of patients will tend to place emphasis on the needs of the patients in recommending equipment and supplies for purchase.

Time- and labor-saving aspects are considered, as well as the acquisition cost. The merits of standardization should be evaluated in final results rather than in acquisition costs alone. Minimum and maximum inventories can be established and priorities decided for replacement and additions. Once standards and stock levels are established, the procurement officer can develop specifications for the type or grade desired. Inspection on receipt of delivered items helps to insure that specifications are met.

A number of questions must be answered during our discussion: What relationship do food, clothing, ward furnishings and other equipment have to establishing a good climate for treatment of the mentally ill? Do equipment and supplies have an effect on employee morale? How does the hospital administrator assure himself

that the individual needs of the patients are being met? How can he best provide his staff with the equipment and supplies essential to carry out a prescribed program? How can he be sure that newly developed items will perform as claimed by the manufacturer? How can he interest manufacturers in developing or modifying equipment to meet specific needs?

Should he rely on the hospital's procurement officer alone to make these decisions on his behalf? Or should he rely on the skills and talents of other members of his staff?

Another point to be considered is that of planning for the procurement of equipment and supplies within budgetary limitations. If those responsible for the management of various departments take some part in the preparation of budgets, would the allocation of funds to the various areas be simplified?

Because of the law, many hospitals must utilize products manufactured or processed by other state agencies, irrespective of quality. There is some need to evaluate the economic aspects of such purchasing practices.

Some hospitals feel that bulk purchasing is less expensive than purchase of material packed in units of issue. Others feel that packing of supplies by hospital personnel is obsolete, is time wasted at the expense of patient care. Any supplies or equipment that save personnel-time eventually pay for themselves. The efficiency of purchasing cannot be determined by acquisition costs alone; the cost of handling must be considered, too.

Some hospitals permit staff members to procure for their own department direct from the vendor. The question here is whether centralized control of purchasing and a central store system would result in a higher level of patient care.

Discussion:

Participants: Mr. Carl E. Applegate, Calif.; J. O. Cromwell, M.D., Idaho; Mr. Robert Klein, Ill.; Simon Kwalwasser, M.D., N. Y.; Elsie C. Ogilvie, R.N., Wash., D. C.; Francis J. O'Neill, M.D., N. Y.; Lucy D. Ozarin, M.D., Wash., D. C.; Walter Rapaport, M.D., Calif.; Mrs. Anna Scruggs, Okla.; Hon. Harry Shapiro, Pa.; Mrs. R. R. Tamargo, N. Y.; Mesrop A. Tarumianz, M.D., Del.; Gale Walker, M.D., Pa.; Mr. Ralph E. Young, Kansas.

In the past we have adhered to a great deal of regimentation in our procurement programs. Central Purchasing has not always left room for the individual needs of patients. Even though Central Purchasing may be mandatory in a large state, there is no need to let this department tell hospital staff members—doctors, nurses and others—what kind of supplies should be purchased for patients. There are various kinds of communities and various kinds of culture. What would be suitable in a rural area would not be suitable in an urban area. Central Purchasing will not save us money if goods are bought which are not utilized with pleasure and with dignity, said Dr. Tarumianz. Individual hospital staffs, taking into consideration their philosophies and their patients' needs, should have a voice in the goods which are purchased.

Taxpayers' money is wasted if we buy a thousand pairs of pants all exactly the same because we get five per cent off. On the other hand, certain commodities are better procured under the control of a Central Purchasing Office. It is only when Central Purchasing has the final say in goods to be individually used by the patients that it becomes a bad practice.

For such goods, purchasing could

be arranged in such a manner that the hospital could have a store like any commercial store, where there are racks for clothing, shoes, and so on, and allow the patients to choose.

Implicit in this discussion is the belief that supplies and equipment have an effect both on patient and on personnel morale. Studies are needed to evaluate just how effective various types of equipment and supplies are in the patient's treatment. If large quantities are ordered, naturally the administration feels they must be used. Yet we are there to treat the patient and help him get well—not to see whether we can save money.

In some hospitals, equipment replacement and equipment budgets are originated at the level of the attendant, the nurse and the head nurse. These people have a chance to express their needs with some hope of having them included in the budget. In some cases, even patients have been consulted and some helpful information and suggestions have come from them.

In California, the Assistant Superintendent, Business Services, in each institution has complete responsibility for plant maintenance, feeding, budgeting, accounting and requisitioning. But while purchases must be made on specifications, the hospitals set up committees to work out these specifications for the kind of goods they wish. One committee, for instance, is composed of a medical man, a business man and a member of the nursing service. This state has had Central Purchasing for many years, but the specifications group on the state level works with the institutions desiring the commodities. They do not have to buy the lowest-priced article. Both quality and price are considered.

The state hospitals did, however, run into some difficulties, and as a result a new bill was passed recently in one state which required that everything over a thousand dollars must go out on bid. But the Bureau of Purchases must purchase the type and quality of material as specified by the requisitioner. Within the framework of this law a committee was appointed by the Governor to set up standard specifications for various commodities. The committee is composed of people in business, in the State service, the Director of Mental Hygiene and

others. If a vendor objects to a bid let by the Bureau he may appeal to the Committee. A department which is dissatisfied with the goods delivered may also appeal to it.

Items supplied and made by the prison industries must compete in California with private industry; orders are not placed just because the item is made by a prison industry. Quality and quantity and price are taken into consideration.

Up-to-Date Standards Important

Dr. Walker said it was obvious that a procurement and supplies program will break down sometimes, on the basis of human error, both within the institution itself and within the Central Purchasing Department. Many times things are ordered by the purchasing agent which the requisitioning individual did not want. Orders for major equipment may get changed in the Central Office, so that the institution has to pay installation fees which could have been avoided if, as requested, the equipment had been bought f.o.b., installed. Sometimes the institution doesn't get its money's worth because the Bureau of Standards doesn't keep up to date. There is grave danger of apathy, so that once a standard is developed, it stays put and is not brought up to date at proper intervals in keeping with the development of more suitable goods or changing needs.

Some hospitals start with preliminary budgets prepared for each operating activity. Sometimes they look like a letter to Santa Claus, but even if the department heads do not get everything they ask for, they are certainly not apt to get much which isn't outlined in the request. The staff are as specific as possible regarding requisitions, using catalogues, illustrations, advertisements, and so on, to give them the exact knowledge of what they feel could be useful. While the Director of the Budget is charged with writing the specifications, a detailed purchase request helps him know what is needed, especially with regard to quality. If in addition there is centralized delivery and centralized inspection, inspectors can work within the trade to get the quality required.

Mr. Young said that the state of Kansas had trouble with the purchase of women's dresses. The Central Pur-

chasing Department was determined to let the award to the lowest bidder. The Commissioner's office therefore had half a dozen of the better-looking secretaries model the dresses and took photographs of the girls wearing four or five different manufacturer's samples. The men in the Purchasing Department knew what these girls looked like when they were properly clothed and when they saw them in these "sacks," that stopped the argument.

Mrs. Scruggs invited the state purchasing agents in to her school for a visit. She took them into the laundry to see what happened to cheap, badly made dresses when they were handled roughly. She also showed them dresses which had been in use for two years because they were of good material.

Other Successful Procedures

In Arizona, which does not have Central Purchasing, Dr. Wick's hospital has set up a hospital purchasing committee consisting of the business manager, the housekeeper, the laundry manager, the director of nursing and the maintenance engineer. Purchases are made on a quarterly basis, and clothing is repeatedly checked for quality and wearability by the laundry and by the ward personnel.

After some months of operation a routine procedure was established. After bids are submitted and samples of material are received, the Purchasing Committee inspects each sample to see whether it meets the specifications. They do not necessarily pick the one with the lowest bid.

Much of the foregoing discussion concerned items which were not standardized, but certain items are standard equipment. There are a number of important agencies in the country, several in the Federal Government and some in associations, which write specifications for various types of commodities which the hospitals buy in large quantities.

Would it be valuable if the Mental Hospital Service could provide a facility for screening specifications which do exist, and perhaps create new specifications for other items? Or are there sufficient facilities already for doing such things? It would be possible to get copies of specifications from each state and make them available to others.

Closely allied to the procurement program is the economic value of the hospital farm. There are many who feel that it is not a good business proposition, unless on a small market-garden scale. Many hospitals have severely restricted or entirely discontinued their farming activities. As suburban developments begin to surround the institutions, still more farm operations will cease. Also, fewer and fewer patients are admitted who can suitably be put to work on the farm.

Too often, in the past, patients have been exploited to produce profits for the benefit of the hospital. Yet it is not worthwhile to have employees on the farm produce milk at twenty-two cents a quart when it can be bought for fourteen or fifteen cents.

Nevertheless, there is not universal acceptance of the fact that farming is bad because it does not always show a profit, nor is it true entirely to say that it is unsuitable work for all patients. Unless the loss is so great that it offsets any therapeutic benefit the farm might have, there is something to be said for retaining at least some part of it. Certainly a patient should not be kept in the hospital because he is a good farmer or a good dairyman, said Dr. Rapaport. But neither should he be kept because he is a good carpenter, tinsmith or shoemaker.

Some patients do definitely benefit from farm activities. If we can honestly help a patient and at the same time save the state a few dollars by producing usable foodstuffs, we should certainly do so. Patients need work of some kind. One patient said to a superintendent, "I don't know what I am going to do when I get out of here. All I do is play. I dance, I sing, and we engage in musical programs. But when I go home, I have got to work."

A very real problem in many hospitals is that there is not enough for the patients to do. Work is a part of the over-all therapy of a patient. The people who are our patients need something to occupy their time, recreation, occupational therapy, and for that matter, helping keep the kitchen clean, clearing the tables, serving their own food and keeping their rooms clean.

In areas where most patients come from a farm they like to work on the hospital farm provided it is modern

and well equipped. Often the experience there will be helpful to them in their vocational outlook. Dr. Cromwell in Idaho tries to make his farm operation a genuine experience in rehabilitation. If you can indoctrinate the farm employees with the knowledge that farming is a part of the patient's therapy, you can have a very desirable situation. Moreover, this superintendent reports that his farm pays its way as well as providing therapy for his patients.

If all farming were to be discontinued today, we might injure or adversely affect a small number of institutions. But this is not really necessary. It is necessary, however, to evaluate the patients' needs and keep farm operations that they can do with benefit. One possible advantage to closing the farm, said Mr. Shapiro, might be to free the superintendent from activities in which he is not primarily interested and which he is not primarily equipped to handle.

One New York hospital in an increasingly urbanized community did away with the pig farm—thus at the same time losing a lot of gulls which used the outbuildings for nesting in

the winter. The farrow house was turned into a fine little laboratory. The dairy farm is being discontinued too, because most of the patients come from New York City. Farm operations in this area are obviously unsuitable, yet in certain sections in the Western area of the country they are obviously useful and even profitable. It is impossible to make any categorical rule about whether all farms should be abolished or not.

No one approach will cure all patients, nor is any one approach going to harm all patients. We are not yet sure enough to say that if we close up all our farms, keep all our people inside and give every one a doctor and two or three nurses they will get well overnight.

Just because in the old days patients were worked for twelve or fourteen hours a day for seven days a week, we need not say that no farms should be operated any longer. We should let patients work on them only if and only so long as they are being benefited. When a patient is ready for a different or more privileged type of work or to go home, he should be taken off the farm.



Most administrators believe that patient and employee morale is affected by the quality of supplies and equipment and that taxpayers' money is wasted unless goods are used with pleasure and satisfaction.

Administrative Inter-State Reciprocity

Discussion Leader: Dale C. Cameron, M.D., Minn.

Presentation:

Many States now arrange for the inter-state exchange of mental hospital patients. Other types of inter-state cooperation are developing, notably the Interstate Clearing House for information established by the Council of State Governments, as a result of the Governors' Conference on Mental Health in Detroit in February 1954. Another result of this conference, the regional Conferences of Governors, is leading to the pooling of educational and research facilities and the sharing of specialized facilities operated by one state but not available in neighboring states.

The Southern Regional Education Board, which has been in existence for some time, has now established a Commission on Mental Health. In November 1954 this group recommended that the States contribute funds to carry out inter-state functions, establishing a pattern of state legislatures contributing money to inter-state activities.

The Northeastern States group met in Wilmington in the spring and discussed the question of patient transfer, pooling of research funds, training and facilities, and also the question of inter-state sharing of special facilities, especially those for emotionally disturbed children.

Discussion:

Participants: Mr. Carl E. Applegate, Calif.; Mr. D. K. Boynick, Conn.; Mr. Willard L. Couch, Ill.; Mrs. Jewelle Dugger, Okla.; Harold L. McPheeters, M.D., Ky.; Winfred Overholser, M.D., D. C.; Arthur W. Pense, M.D., N. Y.; B. F. Peterson, M.D., Tenn.; Mr. William C. Ryan, Ore.; Mesrop A. Tarumianz, M.D., Del.; Mrs. Virginia S. Williamson, Fla.; Mr. A. C. Yopp, Kans.

Dr. Tarumianz discussed the Northeast Conference, saying that Delaware also belongs to the Southern Conference. The Northeast Conference ap-

proved a compact late in September and requested that each state in the conference submit this to its Legislature. It would become operative in each state as the Legislature ratified it.

This compact provides for transfer of a patient regardless of his legal residence, provided it is for the benefit of the patient. The Board which considers each case consists of three psychiatrists and an administrator. If this Board considers it in the best interest of the patient to be transferred, he will be transferred, regardless of any other legal aspects. All of the 40 legislators at the Conference were favorably inclined to the idea.

The whole philosophy of the compact is that the transfer of a patient is a medical and not a legal problem. This type of compact overrides state statutes, pointed out Dr. Overholser.

With such reciprocity, said Dr. Pense, each state would probably end up with about the same number of hospital patients but the approach would be more humane.

Mr. Ryan said that they had checked five-year repatriation figures, and found that they had received two more patients than they had sent out.

Certain states, Florida and California, where older people tend to congregate might perhaps bear a heavier load if they entered into such compacts. People with 40 or 50 years' legal residence in another state come to Florida or California to retire. Their children are far away. What should be done? Transfer the patient back to his home state or care for him where he is?

The Northeast Compact is an interesting experiment which is well worth watching. People in other states can learn something of the pitfalls of such an arrangement, and as a result can perhaps develop more comprehensive and satisfactory pacts. The details of the compact cover a great many legal contingencies which were not discussed in detail at the meeting. Briefly, the compact tends

to ignore the legal residence of a patient coming from any one of the compact states. The overriding principle is the patient's right to be taken care of in the hospital best suited to provide the services he needs. There would be no exchange of funds for this kind of reciprocity.

Dr. Cameron asked if all states represented could pay for the training of psychiatrists, nurses and social workers outside the borders of their own state?. It was apparent that most people present were able to utilize state funds so that individuals could receive necessary training elsewhere.

In Kansas, the State Social Welfare Department has a central training fund; the chief categories being trained outside the state are nurses and teachers for exceptional children. Those trained outside the state agree to come back to the state and serve for a given period of time. Mr. Couch said that in Illinois they have a similar arrangement.

Dr. Peterson described the Southern Regional Education Board which provides for the development of regional training centers. At present Tennessee sends personnel outside the state for advanced training.

Dr. Cromwell said that the Western states are now setting up a similar inter-state program. These states already have a higher education compact, and this is being extended to the hospital and mental health training programs.

Various discussants pointed out the value of such education compacts: the pooling of institutional facilities, enabling personnel to get training in special areas, such as child psychiatry in one place, and perhaps another type of training somewhere else. Even patient care can be improved by pooling some facilities.

In speaking about research it was felt that all the states should have their own research programs although there is considerable merit in trying to develop regional research facilities as well. Regional facilities have the advantage of being able to draw together large numbers of individuals from various disciplines to attack a particular problem. There is one big disadvantage in that if research activities are separated from the state hospital, both patients and staff lose the stimulation research provides.

Outpatient Clinic Services for the Mentally Deficient

Discussion Leader: Robert S. Garber, M.D., N. J.

Presentation:

It is hoped that the people who have had some personal experience either in clinics already established or those who are now developing clinics will discuss the problems they are facing rather than the good things they are doing. For instance, we are not paying enough attention to detail in studying the mentally defective patient. We are not paying sufficient attention to the parents' needs. We do not know how much responsibility the community should have. What are we doing to prevent the dissolution of the domestic relationships of the parents and the siblings? How can a baby sitter be found for a mentally defective child being cared for at home? We need to take several days to do a work-up on the child, just as he would be worked up if he had a neurological condition, an ulcer or a bad gall-bladder. We need time to work with the parents so that we make, not one of them, but both of them, in a sense members of the therapeutic team which is going to have to work with the individual child, whether he is in the community or in an institution. So many of the problems encountered in this area, just as in the area of emotionally disturbed children, are parental problems. If parents can be counselled adequately and offered community facilities, many mentally defective children might not have to be admitted to an institution. These are the problems we should discuss.

Discussion:

Participants: Richard E. Bartman, M.D., Kansas; Hugh T. Croley, PhD., Kansas; Theodore Gebirtig, M.D., N. J.; Mrs. M. Hastings, Md.; Irvin B. Hill, M.D., Ore.; Reynold A. Jensen, M.D., Minn.; W. I. Prichard, M.D., Va.; Mr. Alfred Sasser, Jr., Ind.; Mrs. Anna Scruggs, Okla.; Hon. Harry Shapiro, Pa.; Trawick H. Stubbs,

M.D., R. I.; Gale H. Walker, M.D., Pa.; Exie E. Welsch, M.D., N. Y.; Isaac N. Wolfson, M.D., N. Y.

Dr. Jensen said that the extent of mental deficiency made it a very big medical problem which will probably get bigger as time goes on. Various figures regarding the incidence of deficiency are offered—they vary from 1% to 3% of the total population. With the advances of medical science many children born defective are helped to survive.

Another reason why the problem is becoming extremely pressing is the fact that the mothers and fathers of mentally defective children are beginning to organize; there are not only community and state groups, but a national organization as well. These groups are asking for more good clinics throughout the country.

Moreover, the importance of the problem as a medical one becomes obvious when we take into account the tremendous impact upon a family who has a mentally defective child. There are few things which are more threatening to family life than to have to face the acceptance of, planning for and living with a child who is mentally retarded. The parents may disagree about the methods of care; this disagreement cannot but influence the rest of the family. Simple diagnosis is not enough. It may take considerable time, effort and patience to enable the parents not only to understand the child's deficiency but to accept it as well. Who should make the diagnosis? We believe that it is a medical responsibility. What should we do when the diagnosis is made? It is much too easy to recommend placement in an institution when we know that the child is not endowed with the potentials which will enable him to compete successfully in the outside world. So we must give increasing thought to what can be done; help the parents to accept the child and to plan to maintain him

if possible in his home. Some parents' groups are thinking about this. They are thinking about nursery schools for younger children and opportunity workshops for later on; they are trying to see if they can expand special educational services in community schools.

When the parents are accepted by those whom they come to consult, and when these professional people make the child their own problem as well, and are direct and candid with parents, there are very few parents indeed who are not willing and able to accept the facts and help plan intelligently for the child.

Share Planning with Parents

In planning for the child, said another participant, it is important to encourage the parents to come and discuss their problem, tell them what we can do and what we cannot do, let them see the type of care available in institutions and then allow them to decide for themselves. Parents are not nearly so upset if they can get this kind of assistance. If they are relieved of their anxiety to some extent they are better able to adjust to the realities of the situation, to accept the treatment recommended and utilize the facilities which are available.

Dr. Hill said Oregon has set up a group workshop for the parents of mentally deficient children in the state who are not in institutions. Psychiatrists come and give lectures to the parents on child development, pediatricians talk to them and try to give them a general understanding of the whole problem. Then the workshop sessions are set up according to the age level of the children, and little practical points, which are so hard for parents to handle, are discussed.

Mrs. Scruggs described her method of working with parents. Recently the law in Oklahoma was changed so that no child could be admitted ex-

cept on written application by the parents, and with a definite medical diagnosis. The school started a small clinic which developed into a daily outpatient service. A whole afternoon is spent on examining each child. The medical staff carries out the physical examination and the psychologist administers necessary tests. A child psychiatrist comes as often as possible to see children already screened by the psychologist. Meanwhile, whether the child is eligible or not, the parents are taken around the institution. These parents learn what the school can accomplish and what its limitations are; this makes the waiting period easier, and if the child is not to be admitted it helps the parents to decide what is to be done with him. If necessary, the family is referred to one of the child guidance clinics in the state.

Mr. Sasser of Indiana said that he thought this helped the parents' feelings. Not so many years ago, parents abhorred the idea of putting their child into a state school. While the schools are still not perfect, he said, we do live in a democratic society where, if our needs can be defined, we can bring about necessary changes by working together. Making parents aware of the needs is a step in the right direction.

Dr. Welsch said that the physician should expect to assume the responsibility for the total mental health of the family. A family with a mentally deficient child too often focuses all its attention on this child, at the expense of other children in the family. The siblings have their problems—how can they bring a friend home—what about getting married—is this hereditary, and so on?

Dr. Hill said he believed that while the psychologist and the social workers were important members of the team to treat the retarded child, the final responsibility was certainly a medical and a psychiatric one. He would say that he had never seen one child, of say five or six years of age, who was mentally deficient who did not also have a strong emotional component which was also limiting. Moreover, said Dr. Gebirtig, we should realize that many youngsters are actually functionally retarded, and have good potential. The fact is, however, that we cannot find enough child psychia-

trists for children with known average intelligence, and it is all the harder to find one to treat these retarded youngsters, although they do need all the treatment we could give them.

Dr. Wolfson said that we are learning more and more about the etiology of mental deficiency and our main hope lies here.

Dr. Jensen said that mental deficiency, like other medical problems, could not be attacked by any one specific approach—for instance, a psychological test or so. The medical man should make the diagnosis, and he should be trained in the fields of growth and development, as well as in medicine. An error in diagnosis may create further problems which would be very difficult to resolve.

Treatment Must Follow Diagnosis

A well educated psychologist, said Dr. Gebirtig, can invariably make a diagnosis of mental deficiency and feeble-mindedness, though the problem of differentiating between the youngster who is autistic and the feeble-minded child is a medical matter. But diagnosis, however accurate, is meaningless if you don't follow it up by treatment. The diagnosis is vital because you treat a mentally deficient child differently than you do a schizophrenic or neurotic youngster.

Dr. Croley of Kansas said that he thought it took a psychiatrist, a psychologist, a social worker and other people to make a diagnosis and plan future treatment. Such work should be done in an outpatient clinic.

Dr. Jensen said that if we tried to place every child who is mentally retarded in an institution, our problem would be even greater. One important factor is to determine what can be done to maintain an individual who has any potential for growth and development in the community and in the home for as long as possible.

Dr. Bartman of Kansas said they ran a small outpatient evaluation clinic in connection with their hospital. They have been surprised to find how often a child can be benefited by psychotherapy because his disabilities are reversible. This approach, he thinks, is not sufficiently emphasized; only if the child has not been helped by psychotherapy should he be considered deficient and a custodial case.

Dr. Hill said they started a purely diagnostic clinic and do not give the parents any findings. They simply refer the child back to the family physician with their own medical evaluation. This means of course that general physicians need far more training in the field. Dr. Jensen said that we should set up education of physicians at the very beginning of medical school so that when they go into practice they will know how to deal with the mentally deficient patient. He added that far more physicians are becoming sensitized to the problem, and it is important for them to be able to make referrals with as much confidence as if they were referring a patient to an internist for confirmation of diagnosis and recommendation of treatment.

Dr. Hill said that by referring a mentally deficient patient back to the general practitioner, you are literally compelling the community to take some responsibility for his future treatment and care.

Mr. Shapiro spoke of the classification centers being planned in Pennsylvania, saying that a child should not be labelled but should be studied as a complete entity. The classification center was supposed to discover the nature of his difficulties; it would not attempt to treat the symptoms only but would refer him to the right place to receive help. He added that mental deficiency is a long-term problem and too large to be handled by a local community. It should be regarded as a State problem.

There was some disagreement with Mr. Shapiro. Dr. Croley of Kansas said there was certainly need for a diagnostic label in order to make a proper referral.

Dr. Hill said he thought we should try to define just what we expect in the way of services from a clinic for the mentally deficient. Certainly diagnosis is one of the cornerstones; next comes counselling and education of parents; then planning for the future of the deficient child, and then, if this is our responsibility, to plan for the child who is found to be emotionally disturbed, rather than mentally retarded.

Dr. Prichard said we all know the need for diagnostic facilities; the demand is greater than the supply. But we need to know more about the mechanics of setting up a clinic.

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Should it be state supported or community supported? How should we limit its functions if we cannot begin a fully developed facility? The existing mental hygiene clinics have neither time nor facilities to work with the mentally retarded child and his parents, and as a result too many children are sent to training schools who don't really belong there.

Mrs. Scruggs thought that such a clinic was best started, as they had in Oklahoma, at a school; she said that the diagnosis must be determined before the child was admitted.

Dr. Stubbs said that in Rhode Island the establishment of such a clinic was actually started because of the pressure of parent groups. It was set up as a separate entity under the mental hygiene services, and because it was solely for the deficient, the parents did not feel "frozen out" as they had in mixed clinics.

He went on to say that a small special school was set up and it managed to get six or eight children to the point where they were eligible to fit into special classes in public schools.

Dr. Gebirtig said that in New Jersey the law said that the community itself was responsible for the education of youngsters who were educable. A psychologist examines each child, and many of the schools have obtained a well-trained psychologist for this purpose. As a result, there have not been so many referrals to the clinics for the mentally retarded because the school system is assuming some of the responsibility. If the psychologist refers the child to a psychiatrist because it has emotional problems as well, Dr. Garber's hospital can give treatment and supervision.

Mrs. Hastings asked how we could better utilize the services of competent psychiatrists and other medical men since we know we are short of professional assistance in our clinics for the mentally defective. It is one of the responsibilities of the clinic to work with and educate the people in the community. Dr. Hill said he thought there was great educational value in referring the child back to the family physician, until it was possible for psychiatry to take responsibility for each individual child and his family.

Dr. Garber said that he did not think it was as important who made

the diagnosis, or where the child was diagnosed or treated as it was to be able to do something for him besides saying he was deficient and keeping him on a waiting list.

In summing up, Dr. Garber said that there was general agreement that clinics were needed and that some diagnosis and plan should be made promptly so as to relieve the parents of some of their anxieties; that such planning should be realistic enough for the parents to accept it and assist in it.

A clinic could do good service to an institution by orienting the parents as to what would happen to the child if he was to be admitted. If parents were made fully aware of all the factors, they might help keep down the waiting lists by keeping the child at home for a longer period, or managing indefinitely one who did not really require institutionalization. Finally, other community agencies could be oriented about some of the things they could do to share this responsibility.



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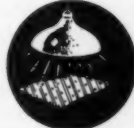
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A Report on The Joint Commission on Mental Illness and Health

Chairman: M. A. Tarumianz, M.D.

Discussion Leader: Daniel Blain, M.D.

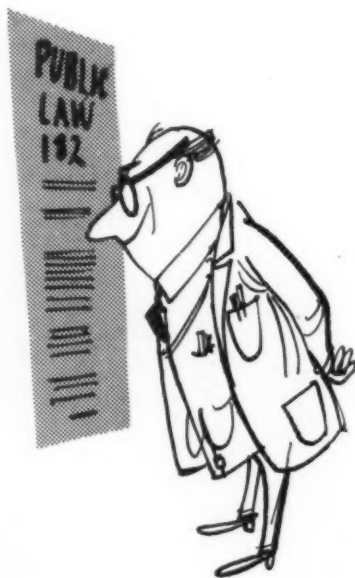
The American Psychiatric Association has participated in the formation of a Joint Commission on Mental Illness and Health organized to carry out the provisions of the Mental Health Study Act of 1955 passed by the present Congress.

This Act, Public Law 182, calls for a nationwide analysis and re-evaluation of the human and economic problems of mental illness, to be carried out by one or more qualified non-governmental organizations. The Congress passed the Act this past session without a dissenting vote in either House. The Act authorizes appropriations of \$1,250,000 over three years, of which \$250,000 has been appropriated for the first year. The money is assigned to the Surgeon General of the U. S. Public Health Service, who may grant it to non-governmental organizations to carry out the study. Private monies may also be used. The act requires that such organizations file annual reports and a final report with the Congress, the Surgeon General, and State Governors. It is hoped that the Surgeon General will approve the application which will be submitted by the Joint Commission on Mental Illness and Health to be the qualified organization to execute the provisions of the Mental Health Study Act.

This idea started with the address of Dr. Kenneth Appel, then A.P.A. President, to the Mental Hospital Institute in 1953, in which he called for such a study.

Following a preamble in which the problem of mental illness is documented, the purposes and policy of the Act reads: "It is the sense of the Congress that there exists a critical need for such an objective, thorough, and nationwide analysis and re-evaluation of the human and economic problems of mental illness and of the

resources, methods, and practices currently utilized in diagnosing, treating, caring for, and rehabilitating the mentally ill, both within and outside of institutions, as may lead to the development of comprehensive and realistic recommendations for such better utilization of those resources or such improvements on and new developments in methods of diagnosis,



treatment, care, and rehabilitation as give promise of resulting in a marked reduction in the incidence or duration of mental illness, and in consequence, a lessening of the appalling emotional and financial drain on the families of those afflicted or on the economic resources of the States and of the Nation.

"It is declared to be the policy of the Congress to promote mental health and to help solve the complex and the inter-related problems posed by mental illness by encouraging the undertaking of non-governmental, multi-disciplinary research into and re-evaluation of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, including research aimed at the prevention of mental illness. It is the purpose of this joint resolution to implement that policy."

Before this Bill was passed, and actually somewhat independent of it, following Dr. Appel's encouragement and leadership, the American Psychiatric Association and the American Medical Association started the formation of the Joint Commission on Mental Illness and Health.

Many Organizations Represented

The Joint Commission was incorporated in August 1955 in the District of Columbia by a small group comprised of representatives of the American Association of Psychiatric Social Workers, American Hospital Association, American Medical Association, American Nurses' Association and the National League for Nursing, American Psychiatric Association, American Psychological Association, and the National Education Association.

The following have also been invited to serve as initial organizational members of the Joint Commission: American Association on Mental Deficiency, American Association of Psychiatric Clinics for Children, American Bar Association, American Occupational Therapy Association, American Public Health Association, Council of State Governments, Joint Commission on Accreditation of Hospitals, National Association for Mental Health, National Institute of Mental Health, National Rehabilitation Association, Social Science Research Council, the U. S. Children's Bureau and the Office of Vocational Rehabilitation of the Department of Health, Education and Welfare, and

the Veterans Administration. Still others will be asked as plans develop.

Dr. Leo Bartemeier is Chairman of the Board of Trustees of the Joint Commission. Dr. Nicholas Hobbs, of the American Psychological Association, is Vice-Chairman of the Board. Dr. Kenneth Appel is being elected to be President.*

The viewpoint of mental hospital experts will be represented on the

Board of Trustees of the Joint Commission. Drs. Walter Baer and Walter Barton are among the trustees, and there is representation of private and public institutions, community services, and the different categories of professional hospital personnel.

In a discussion of the Mental Health Study Act, a State representative reported to the Institute that at the last session of the Legislature sug-

gested improvements were deferred until the report of this Study should become available. This action was viewed as unfortunate, since it will be at least three years before the final report comes out. Progress should not stop in the meantime.

** Since the Mental Hospital Institute was held, Dr. Jack R. Ewalt of Boston, Mass., has been appointed Principal Investigator of the Joint Commission.*

A Report on The A. P. A. State Surveys

Chairman: M. A. Tarumianz, M.D.

Discussion Leader: Daniel Blain, M.D.

Surveys on total needs and resources in mental health are being carried on by the American Psychiatric Association at the request of several states. Their development was described by Dr. Daniel Blain, Medical Director.

State surveys developed spontaneously because A.P.A. was called upon to meet a need. Dr. Blain was asked to serve as an individual consultant in the State of New York to help prepare a report dealing with crimes committed by former mental hospital patients. An objective analysis and statement about release procedures for patients was needed because newspaper headlines about a few sensational cases had created fear disproportionate to the actual situation.

Later the Medical Director was called to Louisiana for consultation. Here it was obvious to the superintendents that they did not have adequate future program plans because they didn't know enough about present circumstances. Again serving as an individual, rather than an A.P.A. representative, Dr. Blain assisted the local group in working up a statement concerning the total situation in the State. This developed into something far broader than a study of hospitals alone; it included community and other services, with emphasis on unused resources.

Feeling that these experiences

demonstrated there was a demand for help which A.P.A. should and could meet, the Council passed a resolution in April, 1954, stating: "The American Psychiatric Association is prepared through the office of the Medical Director to supply professional consultation service to the States in surveys of mental health needs."

From informal representation through the Medical Director in New York and Louisiana, A.P.A. has gone on to complete full-scale surveys in Arkansas, Indiana, and Kentucky. Surveys are now being started in Ohio and Pennsylvania.

The time required for an A.P.A. state survey is relatively short, considering the job to be done: about six months for the smaller states, about nine months for the larger states.

The cost has run around two to three thousand dollars per million of population. In other words, roughly speaking, for a state with two million people it was around \$5,000; for a state with a population of about ten million, around \$20,000. The cost has been estimated on the basis of the extra personnel needed to do the work, so the books are balanced and no money is lost. A.P.A. has come out about even.

Outside aid has been received on this project to organize material and

secure consultation from specialists. This particular effort is financed by the Albert and Mary Lasker Foundation, which made a grant of \$18,000 last year, and which is interested in continuing support of the work in the coming year. This enables data to be collected and used in connection with the information gathered in the states—material gleaned from national and international sources which can be applied to the particular state situation.

In the last few months the Association has obtained national backing in these surveys. Dr. Robert Felix and the regional offices of the Public Health Service have been most helpful. Dr. Fillmore Sanford of the American Psychological Association is officially assisting in looking over protocols and schedules. Assistance has been given by Miss Kathleen Black of the American Nurses' Association and the National League for Nursing, Dr. Ernest Gruenberg of the Milbank Foundation, and Dr. Paul Lemkau.

The staff for this particular service consists of some of the time of the Medical Director, assistance from Mr. Robert Robinson, Public Information Officer; the time of a field representative and a research analyst; and informal assistance from the A.P.A. Central Inspection Board.

No state is surveyed until the Cen-

tral Inspection Board has been in. As a result, material on the hospitals themselves is incorporated from the C.I.B. report in the total state picture.

A very brief description of how a typical survey is conducted will give an idea of their breadth. State survey staff go into each state and hold public hearings of some 50 to 100 statewide organizations of all types, getting them to give information about their organization, their interest in mental health, how it concerns them, and their knowledge about specific problems. These groups become actively engaged in the study.

The Survey Service gets a great deal of background material: information about demography, economics, general health, welfare, rehabilitation, education, general recreation, family case work, activities of religious groups, mass communication media, and cultural factors.

Reports go into the historical development of state institutions and clinics, organization of state mental health program, existing studies of needs and demands, and so on. Staff people study the organization of state government and the various activities of the Federal government, municipal governments, and private organizations and agencies in the state.

All Psychiatric Facilities Reviewed

They assess the number of existing inpatient and outpatient psychiatric facilities, including public and private hospitals and clinics; they get information about numbers and types of patients, and data about related services such as vocational rehabilitation.

They consider the subject of personnel and training. They go into that more thoroughly from the standpoint of psychiatry than most studies that have been made. The A.P.A. has information on punch cards on every A.P.A. member and a large number of psychiatrists who do not belong to the Association. The Association has more individual data about the profession than any other specialty of medicine has for its members. This enables it to give a state a great deal of information, such as the age, training, and previous experience of its psychiatrists, and to point out in what direction to go.

Our friends in other fields, such as psychology and occupational therapy, are helping through their consultants

to approach this matter in as thorough a manner as possible for other professions.

The staff delves into the subject of research. They rely mainly on the material that is available, but also find much work going on in counties and agencies which never finds its way into the national and state reports.

They get information about public education and what is being done to prevent mental illness. They find out what is in the curricula of teachers and the various professional groups to train them in work related to our field, and get as many facts as possible about community education activities, mass communication media, and so on. They consider the general subject of needs of the schools in this area.

Laws and Special Medical Problems Are Investigated

They go into the matter of laws, the organization of local laws in the state, commitment laws, relationship to the courts, the needs of the courts, the needs of existing psychiatric clinics and the attitude of judges.

They assess the special problems of alcoholism, aging, drug addiction, industrial psychiatry, and so on.

Attention is given to programs of special education, the incidence of exceptional children, special schools and classes, teacher training and certification. They gather as many facts as possible about programs for the mentally retarded.

Finally, they summarize with maps and simple tables information which lends itself to this type of presentation.

A lot of the information they might want is not necessarily available. Frequently they are able to point out: here is a place you have to move further along and get more information for your own good. The value of the survey in this instance is in pointing out what is lacking.

With the full picture revealed, the Survey Service tries to come up with some sort of answer which is the combined thought of all the people on the local committee organized in the state. This group, usually appointed by the Governor, consists of fifteen to twenty-five prominent civil and professional people. They try to arrive at a consensus of opinion on which all will agree. This leaves a strong residual

group in the state closely associated with the formation of the report. It is hoped that they will carry out the recommendations after the A.P.A. has completed the study.

This in brief is the formula. It produces a survey somewhat broader than any large studies we know of. It is relatively simple in manpower. It is relatively quick. It is cheap, considering the cost of most surveys.

Reports Considered Notable

An Institute delegate said he had seen some of the reports, and that they constituted one of the most important collections of information and recommendations for the total mental health program of a state he had seen anywhere. They should be read not only by all the people dealing directly with mental health but other people in the field—school teachers, attorneys, and so on. Could other states also get copies of the surveys?

The A.P.A. contract calls for delivering 100 or 200 copies of the report to the Governor. Usually that number is enough to give every member of the state Legislature a copy. After the Louisiana group received the Blain Report, a short summary was made up and many thousand copies printed. In the two states where the A.P.A. is now making surveys it is hoped to have both complete reports and shorter summaries.

The contract for the report is made with the Governor or the department head concerned. It is not confidential. The press frequently sits in on committee meetings. But the A.P.A. gives the report to the Governor, and release is up to him. In every state surveyed, the Governor has given it to the press.

A comment was made about timing of release of the survey. One state survey was released when the Legislature was in session. By this time the program of the Legislature was so stratified it was impossible to make effective use of the report in developing a program. A lot of the fire and enthusiasm for such a program for the next session of the Legislature was lost. For ideal timing the report should come out six or eight months before the Legislature goes into session. This gives opportunity to meet with legislators and discuss the report with them.

ADMINISTRATIVE CAREERS IN HOSPITALS

Chairman: Granville L. Jones, M.D., Va.

Discussion Leader: Francis J. O'Neill, M.D., N. Y.

Presentation:

Younger men, coming into medicine, want to be clinicians. They do not want to be administrators—they seem to think they are an inferior form of life! But most of us think that a hospital administrator's profession is an honorable one. The founding fathers of the American Psychiatric Association and their contemporaries were primarily successful mental hospital administrators. At the time of the founding of the Association, emphasis was on moral treatment—providing good hospital environment to promote the moral rehabilitation of the patient. This is not to say that they were not good clinicians, but so little specific therapy was available that emphasis then was necessarily on administration.

During the past twenty-five years there has been a pronounced change in thinking, so that today the clinical aspect of the psychiatric hospital is paramount. We have successfully treated so many patients by medical means that there has been a shifting emphasis from administration to therapy.

After several years of experience in a mental hospital, many psychiatrists begin to develop a liking for and an interest in the administration of the hospital. Good clinicians who find they are thus able to extend the scope of their clinical work by entering the administrative field make the best administrators.

In the large hospital, a psychiatrist who embraces administrative responsibilities may allow himself to be in almost complete isolation from specific therapeutic contacts with patients; this sometimes leads to sterile professional existence which is frus-

trating and deteriorating. Perhaps we should broaden the base of administrative responsibility to permit the high-level administrator time for therapeutic activities as well.

In some states, although the law places full responsibility upon the hospital superintendent, highly trained, non-medical business administrative assistants are provided to assist him. This may, in theory at least, give him time to continue his interest in individual treatment.

Until a uniform method of training and selecting of administrators is adopted there will of necessity be confusion and lack of coordination in the appointment of psychiatric hospital administrators. There are strong forces at work to introduce non-medical, non-psychiatric administrators, but this Association and its members have taken a firm stand. We are dedicated to the continuation of medical administration of our psychiatric hospitals; only a physician can fully realize the serious harm that would result if we surrendered our hospitals to lay administrators.

Thus the Association is endeavoring to set up uniform standards of training and to make the position of hospital administrator attractive in more than salary and prestige. Accordingly a Committee of Certification of Mental Hospital Administrators has been set up to examine credentials and candidates for certification and to establish rules for certification. Appropriate certificates of approval are granted to successful applicants. However, psychiatrists who have graduated from medical school after June 30, 1947 will, in addition to experience, be required to have had a minimum of one year's aca-

demic training or its equivalent in the various aspects of mental hospital administration before they can be examined by the Committee.

Whether this new requirement of academic training in this specialized field will attract competent psychiatrists to the field of administration, or whether it will add another barrier between clinician and administrator has not yet been demonstrated. The process of selection may be hindered or expedited. Only time and experience will answer this question.

(Discussants were handed a mimeographed document entitled "Ideas of Doctor-Administrator Background for Superintendencies of Mental Hospital" which was written by Mr. Aris A. Mallas, Jr., Texas Research League. In brief, this document stated that while the ideal person to be the chief executive in a state mental hospital is a psychiatrist-administrator, the shortage of such people made the idea unrealistic. Competence both in psychiatry and administration, it stated, required expertness far above that which is usually attributed to the average professional person, nor was there any likelihood that the number of such people would appreciably increase in the years to come. There was a tendency for psychiatrists to under-rate the need for a smoothly operating administrative structure. Our state mental hospitals have not attracted good doctor-administrators; in many instances they have not attracted good doctors, and certainly they have not attracted good hospital administrators. "It is fair to say," Mr. Mallas wrote, "that if good administrators had been available to administer the mental health programs of the various states, they would not have been

in the condition they are today." He recommended that we begin to take into the mental hospital well-trained hospital administrators and train them to operate 1,500-bed (and up) institutions. This would relieve the drain on top psychiatric talent by releasing these psychiatrists for jobs within the scope of their professional training.)

Dr. O'Neill said that he was violently opposed to the premises Mr. Mallas put forth, but said that those who feel that non-medical administrators would be good for our psychiatric hospitals have a right to be heard. He called upon Mr. Robert H. Klein, one of the proponents of this suggestion, to open the discussion.

Discussion:

Participants: Mr. Carl E. Applegate, Calif.; Crawford N. Baganz, M.D., N. J.; Mr. Joseph R. Brown, Ind.; Anthony K. Busch, M.D., Mo.; E. H. Crawfis, M.D., Ark.; Mr. Robert Klein, Ill.; Louis V. Lopez, M.D., N. Y.; H. C. Moorhouse, M.D., Ont., Canada; Arthur P. Noyes, M.D., Pa.; Elsie C. Ogilvie, R.N., Wash., D. C.; L. P. Ristine, M.D., Ohio; G. D. Tipton, M.D., Calif.; Rodolph H. Turcotte, M.D., Mass.

Mr. Klein said that the Texas Research League is a private non-profit organization which at the request of the Governor of Texas made a study of state government operations, including the state hospital system. This very large study was completed some time ago, and when he met Mr. Mallas, Mr. Klein requested him to put his ideas on the subject in concise form. This was the document which was passed out to the discussants.

Dr. Baganz said that he did not think that Mr. Mallas' point of view was objectively presented. He had made the statement that it is not realistic to suppose that the supply of first-rate psychiatrist-administrators would appreciably increase. Dr. Baganz pointed out that there are now 325 psychiatrists certified by the Committee of Mental Hospital Administrators. There is some indication that this number will be increased considerably in the future. Does the possession of an M.D.—a higher educational degree—automatically disqualify a man to be a hospital administrator?

Dr. Noyes said that he could not conceive of anybody being a successful mental hospital administrator unless he is also a well-trained psychiatrist. Since every single administrative act, no matter what it was, had some direct or indirect influence on the care of the patient, only a man trained in psychiatry could possibly fulfill his primary function—to operate the hospital around the needs of the patients.

Psychiatrist Must Lead Team

There are many lay persons in a hospital—business executives, personnel officers, and so on, who felt that they were professionally oriented, said Dr. Tipton, but in the last analysis it has to be the psychiatrist who keeps the organization in balance. These lay people will offer suggestions for improvement. Frequently these suggestions have nothing particularly to do with increasing the level of care the patient gets. They are often to do with some nicety which does not bear on patient care in any way.

Dr. Lopez believed that men trained in hospital administration could assist the Superintendent greatly in the non-medical aspects of the operation. But a patient-centered personnel force must be led by the administrator himself; his policies and his personality pervade the entire hospital. If the leader were not a psychiatrist, how could he obtain the teamwork needed? Is leadership ever mentioned by the "professional" administrator?

The psychiatrist-administrator should have in his organization the proper people in the proper places. He should be the leader of the whole group. Then he should delegate or deputize to the various people who assist him in the operation. Lastly, he should do the most important thing—supervise all these people to see that they do their work correctly.

Miss Ogilvie said that Mr. Mallas' document put emphasis on the efficiency of all the different mechanisms that have to do with hospital operation, but very little upon the patient himself. And the care and treatment of the patient is the primary purpose of any hospital.

The Texas group stated that they omitted reference to matters relating

to the care of the patient, said Dr. Ristine. Mr. Mallas himself had no authority to speak as this was his only contact with mental or other health institutions. Dr. Ristine said he had pointed out to them that they had overlooked one essential point—that all mental hospitals have sought or will seek accreditation from the Central Inspection Board of the American Psychiatric Association with the Joint Commission on Accreditation of Hospitals (composed of the American Medical Association, the American College of Surgeons, the American College of Physicians, the American Hospital Association and the Canadian Medical Association) and that there was nothing to indicate that these groups would ever accredit hospitals under the kind of administrative system recommended.

Mr. Mallas had written "A well-trained administrator, above all, is the type of person who understands fully how to use all technicians in the role for which they were trained, all working together in a smoothly-coordinated team." Dr. Crawfis commented that it seems to him that a good psychiatrist who is doing a good job of coordinating the work of other physicians, psychologists, social workers, psychiatric nurses and therapists of all kinds, is doing this very thing. He thought the techniques of administration could be learned in a very short time. Human relations is emphasized in all schools of administration and the psychiatrist starts out with a hundred-yard advantage.

Layman Opposes Lay Administration

Mr. Applegate said that as a layman with more than thirty-three years in mental hospital work, he was definitely opposed to any layman becoming the superintendent of a mental hospital. A superintendent can secure advice and suggestions from a group of medical and non-medical people, specializing in various fields. But the final decision must be his responsibility.

Mr. Brown of the Indiana Association for Mental Health said that Mr. Mallas' proposals had a "certain simple-minded validity" which would appeal to some legislators. There is a belief that a businessman can take care of business better than any doctor. But the psychiatrist-administra-

tor of a mental hospital can do several things which the layman cannot. He cannot only take broader responsibility for the hospital program, but he can often, because of his status, get more money and more facilities for patients than a lay administrator can get. His status enables him to resist the inroads of patronage policies.

Dr. Baganz said that mental hospital administration had been described as the treating of patients on the wholesale basis instead of retail. The direction of such an institution which, whether it be 22 beds or 15,000, should be that of treating the patient, so that the director of this treatment program would logically be a physician.

Training Programs Developing

Why should the mental hospital administrator feel, even though he does treat both personnel and patients wholesale, that he lacks clinical contacts? The people who work in mental hospitals have their own problems, which result in various types of work performance, attitudes, ideologies, instincts, wishes, motives and drives, all of which result in different kinds of interpersonal relationships within the hospital. The administrator who is a psychiatrist has a certain advantage in that he can understand, for instance, aggressions in some individuals. By this kind of understanding of employees' problems we can perhaps salvage many employees who would otherwise be lost.

Dr. Busch wondered if there was at the present time sufficient good training for hospital administrators. At Barnes Hospital, the students come out one afternoon during their year of training for a lecture on mental hospital administration. Surely every good psychiatric training center should set up courses in mental hospital administration.

Dr. Baganz pointed out that in addition to the Menninger Foundation School of Mental Hospital Administration, started in September 1955, a course has been established by Columbia University's College of Physicians and Surgeons. This course has been approved by the American Psychiatric Association Committee on Certification. There is also the Yale University School of Hospital Administration, planned primarily for the private,

voluntary, non-profit hospital. Yale is also working on a pilot plan with a grant from the Public Health Service to set up a school of Mental Hospital Administration in addition to their school for Hospital Administration, because they realize that the needs in the two fields are not parallel. Columbia is establishing a separate school. Dr. Harry Agnew at the University of Toronto has done some preliminary work in the same field, and so has Dr. McGibony at the University of Pittsburgh. The University of California has become interested, and the state may establish schools of mental hospital administration. Dr. Ray Brown of the Chicago University School of Hospital Administration has expressed interest in establishing separate courses in our field.

Dr. Moorhouse said that Dr. D. R. Fletcher, by whom he was trained, used to say that he did not see how a young psychiatrist could operate in a mental hospital without interesting himself in its administrative processes, because they were a part and parcel of his business as a clinician of caring for the patient. He thought that if we remembered that attitude, we need have little or no difficulty in procuring more psychiatrist-administrators. Hospital psychiatrists would drift into administration almost automatically; they could not help themselves.

Administrator Influences Many

Dr. Turcotte said that he thought mental hospital administration is the thing of the future. Today, perhaps, the administrator is at the bottom of the prestige pile, because young residents don't even want to do group therapy—they want to sit down with a patient alone and become some kind of psychoanalyst. Yet if the administrator is a good administrator, he can, through his influence, exert a beneficial effect on large numbers of people throughout the hospital.

Mr. Klein, noting that time was short, said there was one point that he would like to make. He was the only protagonist present for the layman-administrator, yet the subject took up much time and attention from the group.

He thought that there was confusion between the functions of a hospital and its general operation. There could be no question as to what the

functions of a mental hospital are. They are, of course, the treatment, the hoped-for cure, and the return to society of the mentally ill.

Recognizing that there is a very, very great difference between the operation of a general hospital and a mental hospital, he felt he must say that the same kind of arguments presented in the discussions were presented a few years ago that a lay administrator should not become the chief administrator of a general hospital. That subject is still being debated in the American Hospital Association.

Difference Between Hospital and Factory

If there were an excess of psychiatrists available in the United States today, he thought the arguments advanced might be justified. But there is not, and moreover young psychiatrists are less interested in administration than in clinical work.

Finally he would like to say that there are many men who head technical and scientific organizations in this country today who have no knowledge of the processes in their organizations, but who are excellent administrators.

The point was raised that there is a vast difference between managing a factory or a commercial operation and gearing every operation in a mental hospital for the single program of treatment of patients. It was further pointed out that recruiting of personnel in psychiatric institutions, where full-time professional staff was used, was always more successful when the superintendent himself was a professional man.

Summary

In summing up, Dr. O'Neill said that the group was in complete disagreement with Mr. Klein's premises, and the validity of his arguments, but that he had a right to voice them in this forum.

The Chairman added that in fairness to Mr. Klein, he had to admit that this was a loaded audience! The matter was not entirely one-sided. In all fairness, and to keep our own thinking sharp, we should perhaps hear a few more such statements supporting the opposite point of view.

The Role of the Hospital in Psychiatric Public Relations

Chairman: Gale H. Walker, M.D., Penna.

Discussion Leaders: Mr. Edward Brecher, N. J.

Wilfred Bloomberg, M.D., Mass.

Presentation:

The best way to make a man mad is to tell him how to run his own affairs. I am going to provoke discussion by doing just that. My first challenge: Why don't you open up?

Mental hospitals are past the era when a reporter could not go in and talk to anyone, anywhere. Most hospitals are wide open in this respect. But there are other ways of opening up. This has to do with press relationships when something goes wrong. One hospital has been getting unfavorable publicity about a situation for three months. The hospital still hasn't told its side of the story. What appears to the public to be maladministration may be a need for additional funds. More support may be a result of a good public relations decision.

And second, why don't you initiate news? If your institution only gets into the newspapers when there is trouble, this is bad. If there are a hundred stories a year and four or five or six represent trouble spots, the matter is seen in perspective. The play written and produced by St. Elizabeths Hospital's patients and presented for the Institute was announced in the newspapers and the public was invited. Many people came. This is a good example, an exciting example of opening the doors. At a June conference supported by several Foundations held in Swampscott, Massachusetts, the A.P.A., National Association of Science Writers, and Niemann Foundation for Journalism brought psychiatrists and writers together to thresh out some of these problems. One thing brought out was that people think in stereotypes about psychiatrists and patients. If you have a regular, steady flow of news you can gradually change stereotyped thinking.

And finally, why don't you get the lead out of your shoes? More good

stories, more affirmative reports of the kind you like to see in newspapers and magazines, are fouled up and lost because of timing than because of any other single factor. Newspapers and magazines work on deadlines. This is the nature of the animal. A reporter may come around with an embarrassing, awkward question. You are distressed. You think, "Friday we will have a staff meeting and discuss what to do." This is three days away. By then you have had three days of unfortunate headlines. It has to be done quickly in order to be effective.

But if you think you have trouble with reporters and magazines writers, wait until they start bringing TV cameras into the hospital! concluded Mr. Brecher.

Discussion:

Participants: Mr. Joseph R. Brown, Ind.; Philip N. Brown, M.D., Mich.; J. O. Cromwell, M.D., Idaho; George W. Davis, M.D., La.; Hayden Donahue, M.D., Okla.; George A. Elliott, M.D., Mass.; John G. Freeman, M.D., N. D.; W. Everett Glass, M.D., Mass.; Mr. Mike Gorman, D. C.; Irvin B. Hill, M.D., Ore.; Granville L. Jones, M.D., Va.; Mrs. Miriam Karlins, Minn.; Daniel. Lieberman, M.D., Calif.; J. E. C. Morton, M.D., Kans.; Chaplain Moody A. Nicholson, Okla.; Winfred Overholser, M.D., D. C.; Mr. Stanley Rands, Sask., Canada.; Miss Elizabeth P. Ridgway, Pa.; Mr. Robert L. Robinson, D. C.; Reginald S. Rood, M.D., Calif.; Mr. Wm. C. Ryan, Ore.; Herman B. Snow, M.D., N. Y.; Mr. Sidney Spector, Ill.; Mrs. R. R. Tamargo, N. Y.; Edgar Yerbury, M.D., Conn.; Robert R. Yoder, M.D., Mich.

Mrs. Karlins, Minnesota, said TV may not be so threatening as we think. They have brought TV cameras into a state hospital on an alcoholic ward. A woman alcoholic

agreed to give permission to identify her, use her name, and follow her 60-day treatment program. The TV station has run a weekly series, which has received national recognition. The hospital has had more requests for admission to the treatment program than they can possibly handle. It has not been a threat, but a good thing. For the first time people went behind the closed doors; this was not just words.

How do we solve the problem of not giving the names of patients to newspapers, not blacking out their faces in pictures? It is a dilemma. On the one hand the person is presumably stigmatized by being in a mental hospital. On the other hand, we try to run these hospitals as others are run. If a man in a VA hospital had a broken leg, there would be no objection to using his real name and picture.

Publishing a picture with a blacked-out face does more harm for the purposes we all hold in common than an unfavorable headline, was one viewpoint.

A Pennsylvania hospital reported they released the picture of their Christmas Cantata group, giving identification of all the patients.

Dr. Philip N. Brown of Michigan said they had released photographs of patients for three years. They went into it quite thoroughly with the metropolitan Detroit newspapers. Their legal departments were a bit skeptical as to the advisability of doing it, for fear of law-suits. He said facetiously that the newspapers finally agreed to publish the photographs if he would go to jail with them. They have used no masked pictures, and have had no problems. The newspapers have published many photographs, including Sunday rotogravure features. Even if there were a suit which they lost, he conjectured the fine might be a token one of six cents, which could be used itself in promulgation of the idea that these folks aren't disgraced.

Do you get signed releases from your competent patients and from the families of incompetent patients before you release photographs for publication? he was asked.

Dr. Brown said, Yes, voluntary patients sign the release themselves. In the case of the committed patients, the relative or guardian, if there is

one, signs the release. He added, ironically: "I am perfectly well aware of the fact that the law says the committed patient cannot sign the release because he is mentally incompetent, and that the guardian cannot because he isn't the person who is being pictorialized. I would imagine from a legal point of view this could be difficult. But yes, we do have releases signed."

The experience of a Canadian magazine reported at the Swampscott conference shows this taboo may be needless. It was the press, rather than hospital superintendents, that hesitated to use full faces. Finally they decided they would never know whether it was nonsense until they tried publishing photos. They did, and had no repercussions except favorable ones. "How nice to be able to see what these people are like, and that they are like other people. Why hasn't it been done before?" a typical letter said.

A woman lawyer protested the law may say the patient cannot give consent, that even if he can legally give consent, he should not be asked for it. If his picture is in the newspapers, it can be kept for years to come. If later that person should run for public office or seek a job, there is evidence he has been in a state hospital.

Again the historical pageant written by the St. Elizabeths patients was recalled. When the curtains opened there was nothing but darkness. Then a voice came from the dark. Then the lights came on. Then a patient said, "Now we can be seen." "I am sure they also speak for other patients who are perfectly willing to be seen and identified. That is how the patients themselves feel about it," said a superintendent.

Dr. Overholser said a good many troubles arise because the law usually lags behind public opinion. This is a very good example. St. Elizabeths patients have appeared on TV and photographs have been published in national magazines. He said they have had very good legal advice from lawyers for both media. The lawyers are perfectly satisfied with the intent shown by the written consent of the patient. Although commitment does constitute adjudication, no patient's picture is used unless the patient himself gives consent. In addition, they



The pageant written, devised and presented to the public by patients at St. Elizabeths Hospital, Washington, D. C., emphasized that patients themselves were willing to be seen and identified.

have a statement from the doctor familiar with the case that the patient is clear enough to know what he is doing. They also have permission signed by the responsible relative. St. Elizabeths feels that showing the patients' faces has done a good bit of good, indicating that neither the hospital or patient thinks that being in a mental hospital constitutes a stigma.

It was suggested that a public relations program can best be implemented through a mental health organization. Superintendents were urged to get into business with them. Give them responsibilities. Start laying out jobs for local mental health societies so they can help tell the story of what is needed. Don't forget the importance of radio programs. Staff salaries must be raised if we are going to attract good personnel, these groups should be told. Services of volunteers can help the hospital program and public relations, too. Community groups should be drawn into the hospital program, and opening hospitals to the public is a way of influencing public opinion. Press conferences are a useful way of presenting the hospital's story, and so are press tours through a hospital system arranged for a group of writers. Legislators have also been taken on similar tours as a way of showing them what is going on, what is needed.

A superintendent raised a question about the problem of reviewing a writer's article before publication. He

had one on his desk which he felt unsuitable, yet felt criticism might be interpreted as a threat to freedom of the press. He said the writer had a contract for the article in what he characterized as a B magazine. In the doctor's opinion it was a C article, and he didn't know what to do with the D thing.

Robert Robinson, A.P.A. Public Relations Officer, said the Committee on Public Information, of which Dr. Robert Morse is Chairman, is available either directly or through his office for advice on problems of this sort to help work out solutions acceptable public relations-wise and from the standpoint of the medical profession.

This is a counterpart, of course, to the open press policy which the Association has developed with extreme success in recent years. Mr. Robinson said it was five years ago, at the Second Mental Hospital Institute, that the first session on public relations was held. At that time he postulated that we simply had to come to terms with the American press as it operates. It was a radical idea at the time. There wasn't anything approaching a harmonious feeling about this proposition. It is thrilling that at this Institute hardly anyone has talked about these new things they are doing without reporting a uniformly successful experience. This is a wonderful thing. It means we have come a long, long way.

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